ANNEX B

BEHAVIORAL HEALTHCARE SYSTEM ASSESSMENT

Operation Iraqi Freedom (OIF)
Mental Health Advisory Team (MHAT)

16 December 2003

Chartered by:
U.S. Army Surgeon General

This is an annex to the OIF MHAT Report addressing the Behavioral Healthcare System in OIF, including Kuwait and Iraq. The findings were obtained via direct observation, interviews and surveys, and data calls.

This report is redacted to remove unit identifications, unit locations, and personal identity information in accordance with Army Regulation 25-55, *Department of the Army Freedom of Information Act Program*, and Army Regulation 340-21, *The Army Privacy Program*. Redacted information appears throughout this report blacked out, such as below.

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ANNEX B to OIF MHAT REPORT

INTRODUCTION

An objective of the Operation Iraqi Freedom (OIF) Mental Health Advisory Team (MHAT) was to conduct an assessment of the Army behavioral healthcare system in Kuwait and Iraq. The focus was to assess Army wide policies, procedures and resource requirements affecting behavioral health (BH) services in theater and provide recommendations to address potential organizational and resource limitations. To accomplish this goal, MHAT gathered information by utilizing three written surveys (one for behavioral healthcare providers, one for unit ministry teams, and another for primary medical care providers) and two interview schedules (one for behavioral healthcare providers, and one for line leaders). Findings and recommendations are presented first, followed by findings and summary of each survey, interview, and data call. See Appendices 1 thru 11 for details of the surveys and interview schedules used.

FINDINGS

1. The closer Soldiers were treated to their units, the more likely they were to return to duty.

Soldiers who were treated by behavioral health providers in division mental health sections (DMHS) and the combat stress control (CSC) units averaged a 96% return to duty rate. Return to duty rates decreased as the Soldier was treated further back through the medical levels of care.

2. There is a lack of systematic training/education in the implementation of Combat Operational Stress Control (COSC) Doctrine

Over half of the 41 behavioral health providers (see Table 1, Appendix 1 for list of BH providers) interviewed indicated either they did not know what the COSC doctrine was, or did not support it. Further, over half of the BH personnel interviewed reported they had not received adequate training in combat stress prior to deployment. Providers stated there was a need for more intense training in COSC prior to deployment.

3. There is no standardized method to collect BH workload and clinical information.

MHAT reviewed several DoD-supported databases and homegrown databases for the purpose of calculating the percentage of Soldiers who received BH services and returned to duty. No single workload collection system was in place at the beginning of hostilities. BH units initially reported workload data using either the Medical Command (MEDCOM) supported Disease and Non-Battle Injury (DNBI) report, or the experimental Combat/Operational Stress Control Workload and Activity Reporting System (COSC-

WARS). Nine of seventeen (53%) behavioral health units relied on “homegrown” databases for closer workload and patient tracking.

4. Although the number of BH personnel in theater was sufficient to provide coverage throughout the OIF Area of Responsibility (AOR), there were areas in theater that lacked BH services.

While conventional metrics for assessing sufficiency (see Appendix 8) show that BH clinical services are meeting Army operational expectations, Soldiers report significant unmet behavioral healthcare needs (see Annex A). Some areas had very few or no BH services ([redacted] Iraq, [redacted] Kuwait, and in the [redacted]), and few of the smaller forward operating bases received regular BH outreach services.

5. BH outreach efforts need improvement to better meet the needs of Soldiers and line leaders.

Soldiers reported unmet needs for behavioral health services, and many did not know how to obtain services. Commanders and sergeants were generally happy with the support that they received from BH personnel, but reported the time and resources it took to take a Soldier to see a behavioral health care provider was excessive.

Outreach may not be well performed due to a lack of standardized tactics, techniques, and procedures (TTP) for assessing needs and ongoing BH requirements of Soldiers and units. The MHAT noted that current COSC doctrine does not provide guidance for performing needs assessments for units and Soldiers. The absence of an appropriate Soldier/unit needs assessment tool prevents local BH leaders from knowing how to best allocate their resources. Instead they rely on intuition and anecdotal information. Clearly these are not the best guides for medical planning, and can easily lead planners to false conclusions. For example, 90% of behavioral health personnel surveyed believed Soldiers in their area of operation (AO) had good access to BH services. Despite this belief, only 56% of Soldiers surveyed reported knowing how to obtain behavioral health care in theater.

6. Lack of defined standards across the continuum of care from a garrison-based clinical model of practice to a COSC preventive model.

Soldiers and units need both preventive and clinical interventions. However, the MHAT found that some BH units were inflexible in providing both the clinical and preventive services needed by Soldiers in their AOR. These differences exist in part because the integration of clinical treatment and preventive interventions is not clearly defined in COSC doctrine.

7. Inconsistent communication and integration between BH providers and higher medical headquarters.

Thirty-seven (37%) percent of BH personnel reported receiving guidance and adequate supervision from their higher headquarters. Thirty-four (34%) percent reported not getting needed mission information and intelligence. There were no significant differences between the active and reserve components on this issue. Fifty-five (55%) percent of the BH officers were dissatisfied with their perceived level of input into operational planning. Nineteen (19%) percent of all BH personnel reported having input into the policies of their higher command. Command relationships need to be more clearly defined.

8. Shortages of tactical radios and vehicles were an obstacle to conducting outreach.

Seventy-five percent (75%) of the BH officers interviewed in Iraq reported lack of radio, phone, and email access significantly impacted their ability to provide outreach services.

9. Forward-deployed BH units report a greater shortage of psychotropic medications than units located in the rear.

Dissatisfaction with the availability of psychotropic medication was particularly high among Combat Stress Control units and Division Mental Health Sections (57.1 & 66.7% respectively). Unlike units at higher levels of care, these units did not have an integrated pharmacy to immediately dispense medication. Anecdotal reports from forward-deployed psychiatrists indicate that filling prescriptions is unnecessarily complicated and forces Soldiers and units to arrange at least two convoys.

RECOMMENDATIONS

Recommendations, supported by the findings, are summarized below. These recommendations are separated into two periods of implementation: "Immediate" – those recommendations that should be implemented by the current deployed and/or recently alerted (OIF2) rotation, and "Future" – those recommendations that will likely require more time to implement.

1. Appoint a Theater/Area of Operation BH consultant to advise the Surgeon on BH issues

a. Immediate Implementation:

Appoint a BH consultant for each AOR – In order to better allocate BH personnel and to oversee the delivery of BH care in the AOR, the commander should appoint a BH consultant to each theater/AOR surgeon. This officer may be already on staff, or could be requested through personnel channels if a

suitable choice is not available. Example duties of the theater/AOR BH consultant might include:

- Conducts a theater/AOR-wide BH needs assessment
- Establishes BH standards and operational requirements plan
- Recommends the BH theater/AOR evacuation policy
- Prepares the BH portion of the medical operations plan
- Reviews all command/medical policies that affect BH activities
- Recommends proper distribution of BH units/teams on the battlefield
- Evaluates the quality of BH services rendered in the AOR
- Makes regular AOR BH consultant site visits to BH units/teams
- Coordinates with other BH consultants in adjoining AORs and in the primary evacuation chains to ensure unity of effort.
- Oversees in-theater BH training
- Coordinates joint and combined BH services where necessary
- Plans for future BH operations (redeployment surge, etc.)
- Consults with the Surgeon on all BH matters

b. Future Implementation:

(1) Ensure all theaters and AORs have a BH consultant appointed on the surgeon's staff – The creation of a theater BH consultant is not a new recommendation. Martin & Fagan (1996) noted problems with integration among BH units and missions in the first gulf war, and recommended such a position be created. DOD has also directed that each unified command have a BH consultant appointed (DODD 6490.5, para 5.5.2). The OTSG BH Consultants can ensure that doctrine and policy correctly reflect the duties and responsibilities needed in this vital position.

(2) Explore consolidation of all active and reserve CSC units into a unified training structure – Current Army CSC force structure is composed of scattered detachments and companies (see Table 1 next page) reporting to very different commands. A unified AC/RC training structure could coordinate CSC service provision and standardized training during the readiness phase of the deployment cycle, and the cross leveling of resources (personnel and equipment) during the deployment phase.

Table 1: COSC Units in the U.S. Army

UNITS	LOCATION	AC AUTH	RC AUTH	COMMENTS
Active Component Detachments				
[redacted]		24		
[redacted]		42		MRI Complete
[redacted]		24		
[redacted]		24		
Reserve Component Detachments				
[redacted]			24	
[redacted]			24	
[redacted]			42	MRI Complete
[redacted]			42	MRI Complete
[redacted]			24	Inactivating Now
Reserve Component Companies				
[redacted]			85	
[redacted]			85	
[redacted]			85	
[redacted]			85	

2. Conduct an aggressive program of BH outreach.

a. Immediate Implementation:

(1) Ensure BH personnel have a regular, far-forward consultation program at the small unit level – Behavioral health care providers can reduce and/or eliminate many of the barriers to care experienced by Soldiers by physically going to the Soldiers who need and/or want help. Further, preventive efforts (classes, command consultations, debriefings, unit climate assessments) can only be done through regular visits to unit locations. BH personnel must establish a predictable, regular, and visible presence at the company/battalion locations.

Although there were sufficient BH personnel in theater to provide needed coverage, distribution of BH assets was not optimized. For example, the MHAT found that much of [redacted] Kuwait ([redacted].) and [redacted] Iraq ([redacted]) had no BH prevention services and transportation to clinical services required a trip of two or more hours one-way (see Appendix 8).

(2) Increase BH accessibility through liaison with command, UMT and primary care personnel – In addition to direct Soldier contacts, BH personnel can partner with leaders, commanders, chaplains, and primary medical care providers to extend access to BH care. Further, BH personnel need to reach out particularly to leaders and other helping professionals as they often have the greatest direct and indirect BH stressors (Bourne, Rose, and Mason, 1968). Helping these individuals work out their own sleep plans, stress reduction and burnout, should be a vital mission of BH prevention efforts (Jones, 1995).

(3) Implement a BH reconditioning program – Soldiers should be treated as far forward as possible and remain with their units or in proximity to their units. Further, Soldiers who are evacuated often receive little or no substantial treatment along the evacuation route or at home station (see Evacuation Annex). In order to facilitate BH treatment and to minimize BH evacuations out of theater, Soldiers with BH (COSC/psychiatric) issues should be kept in theater (Iraq or Kuwait). A properly placed, staffed, and operated reconditioning unit could successfully return to duty a fair percentage of the Soldiers currently being evacuated for BH reasons. The location should be in the rear (for those on weapons restriction), with austere conditions (to encourage return to duty), far from towns or other distracters (to minimize elopement), and co-located with combat support or combat service support units who could profit from the therapeutic work details the Soldiers would provide.

(4) Ensure adequate BH support for increased demand in services during the upcoming battle-handover – Winter/Spring 2004 will be a major upheaval as units deploy and redeploy. Post-deployment screening will likely require some BH consultation (where Soldiers screen positive on the PDHA BH questions), some units may need debriefing sessions, reunion classes, etc. Deploying units may need stress management, anger management, communication, suicide prevention, and other classes in preparation for the battlefield.

In addition to deploying and redeploying Soldiers, BH personnel should prepare to debrief their returning peers and the other helping personnel (chaplains, chaplain assistants, primary care personnel, etc.) who have often vicariously "contained" the stresses and pain of others over the course of the deployment.

b. Future Implementation:

Train and support a Soldier peer-mentoring program – Since Soldiers are much more likely to turn to other Soldiers for support, training Soldiers to provide early identification, uncomplicated intervention, and referral will provide better, less-stigmatizing support while extending service availability on the battlefield. This model of approach is used successfully by our allies, and U.S. federal, state, and local agencies (see Annex A, Appendix 1). BH personnel in support of each unit (DMHS/CSC) should be tasked with training and overseeing the peer-mentors in their respective supported units. This would minimize cost and maximize the liaison between the supported unit and the supporting BH personnel.

3. Develop and field standardized tactics, techniques, and procedures(TTPs) for BH units and teams

a. Immediate Implementation:

(1) AOR BH consultants need to distribute BH appropriately – The MHAT noted gaps in BH services in theater. In particular, BH personnel were not optimally distributed (see Appendix 8). In order to remediate this, theater BH consultants need to review their respective AORs to ensure that BH personnel are optimally distributed and that the services rendered provide a consistent network of BH services. Where gaps are noted, BH units need to be redirected to provide the needed service.

(2) AOR BH consultants need to ensure BH units/teams have appropriate command/support relations with their supported units – Non-divisional BH units and teams deployed forward to division and brigade units struggle to be accepted and resourced by their supported units. These BH units and teams need to have specific, documented command and support relationships (OPCON, attached, etc.) to their respective supported combat units in order to clarify their "status."

(3) Field a simple, standardized needs assessment tool for Soldiers and units – The MHAT noted that few BH personnel had performed a needs assessment process for their AORs. Creation and distribution of a standardized needs assessment tool can provide guidance for BH professionals until a more thorough set of assessment TTPs can be created under recommendation 3b(1) below. Such an instrument should include symptoms, exposures, morale and cohesion, the desire for help, and barriers to care.

(4) Publish a compendium of "best practices" – The AMEDDC&S or the BH section at CHPPM should gather "best practices" and "lessons learned" from BH personnel who have recently deployed to OEF or OIF for dissemination to deployed or deploying BH personnel. Publication should include website, CD, and limited paper media. Contents should include battlefield survival, outreach techniques, command consultation, triage, restoration, and other COSC issues.

(5) Ensure availability of psychotropic medications as far forward as possible – CSC providers are rarely located close to pharmacy services, and travel between locations in theater is both time consuming and dangerous. In order to facilitate proper and timely care, theater medical commanders should either authorize psychiatrists and psychiatric nurse practitioners in CSC/DMHS units to possess and disburse medication or stock forward support battalions or battalion aid stations located closest to BH medical professionals who can prescribe with adequate psychotropic medications.

b. Future Implementation:

(1) Develop and field standardized Soldier and unit needs assessment tools – Many of the deficits found in theater were due to a lack of proper tools and/or guidance. MEDCOM/OTSG should leverage MRMC, AMEDDC&S, CHPPM, and other assets to develop and field standardized BH needs assessment tools for use by BH personnel in garrison and on the battlefield.

(2) Update COSC doctrine to better delineate staff and command relationships for BH personnel and units – The various divisions command their respective DMHSs, while the medical brigade commands the CSC and Combat Support Hospital (CSH) units. These separate command structures make it difficult to form a seamless BH system. In order to facilitate this, doctrine needs to specify the proper command and support relationships among BH units, teams, personnel, and supported units.

(3) Convene a Process Action Team (PAT) to update doctrine and procedures for BH units (CSC/DMHS) to possess and disburse psychotropic medications – Two-thirds of psychiatrists and psychiatric nurses report there was a lack of adequate psychotropics in theater. Many had no access to them because their unit was not authorized possession or transportation of medications. Based on a similar model to the dental and medical units/teams far forward on the battlefield, CSC and DMHS units/teams need to carry a supply of medication with them.

(4) Publish revised TTPs in COSC technical manual – Although general COSC doctrine exists in field manual form, many of the particulars of how to implement the doctrine across the deployment continuum of care have not been clarified. Tactics, techniques, and procedures (TTPs) – along with appropriate tasks, conditions, and standards – need to be developed and published in a COSC technical manual. These TTPs will then form the basis for BH "standards of practice" for the garrison and deployed environments. Topics should include medication management, confidentiality, BH documentation and convenience file (medical records) management, scopes of practice for the various disciplines, standards for evacuation, methods for needs assessment and evaluation, handling non-voluntary BH evaluations, etc.

4. Ensure all BH personnel are trained/educated in COSC doctrine, tactics, and procedures.

a. Immediate Implementation:

(1) AOR BH consultants should establish quarterly BH training conferences – Not only did a number of BH personnel state they were under-trained, but battlefield execution demonstrated the need for training in COSC doctrine, tactics, and techniques. Theater BH consultants should establish regular (quarterly) training conferences to ensure that doctrine is clearly disseminated and problems are

addressed. Trainings may be centralized, regionalized, or performed via train-the-trainer. Technology may also be leveraged (VTC, telephone, videotape, CD) to accomplish this. However, tapes and talk alone will not suffice without some live demonstration and periodic oversight.

(2) Conduct COSC training for BH personnel (AC/RC) preparing to deploy – MEDCOM/OTSG and the reserve medical commands should ensure that BH personnel (both active and reserve) currently alerted for deployment to theater in Spring/Summer 2004 are adequately trained. This could be accomplished by holding a predeployment conference or by holding regional training meetings. Holding a conference provides the added benefit of allowing the BH personnel to meet each other and to begin to plan and network together.

b. Future Implementation:

(1) Expand existing Occupational Therapy (OT) COSC course into a multidisciplinary course and require attendance of all BH personnel prior to or in route to any TOE assignment – The AMEDDC&S currently offers an OT COSC course. While this course offers a great platform from which to build, the course must be embraced by all of the BH disciplines and be required of all BH personnel, active and reserve, to be truly successful as a COSC training program. In addition to active and reserve BH personnel, the course should be open to BH personnel from other services and departments.

With the high OPTEMPO, it is essential that all BH personnel attend the COSC course. This training could take place during internships, residencies, or the individual's first assignment. Each specialty would be able to flexibly schedule this training into their respective educational lifecycle.

(2) Reorient the AMEDD officer and enlisted military education systems to integrate collective blocks of instruction in COSC, disaster mental health, and battlefield professional practice – Although some of the BH disciplines receive a small block of instruction in COSC, the training is inadequate to properly train BH personnel in their vital "go to war" mission. The AMEDD Officer Basic and Advance Courses need to be examined to ensure they contain adequate amounts of training in COSC TTPs. The COSC Program of Instruction (POI) must also be carefully integrated between each course and the revised OT course discussed in 4b(1) above to ensure topics are adequately reemphasized yet build on each other.

(3) Ensure a COSC/BH track is incorporated into the annual Force Health Protection (FHP) Conference – The annual FHP Conference offers a wide range of military preventive medicine tracks. COSC (preventive behavioral healthcare) is a logical track within the FHP Conference agenda. Courses, workshops, and practical offered there would ensure proper sustainment training for both active and reserve BH personnel.

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5. Develop & field a data collection methodology for BH surveillance and outcome information

a. Immediate Implementation:

MEDCOM should review the COSC Workload and Activity Reporting System (COSC-WARS) for sufficiency and then automate it – Using small-scale technologies (Microsoft Access) for common laptop computers and for the Pocket PC (handheld) platform, COSC-WARS (revised) could be fielded with the BH providers preparing to deploy this coming spring/summer. Although any system devised will eventually need to be rolled up into larger DA and DOD systems, COSC-WARS (revised) could provide a good interim solution using minimal cost, rapid development strategies until these larger systems are fielded.

b. Future Implementation:

(1) Integrate COSC prevention efforts into existing and emerging theater medical databases – As new medical data systems come on-line, BH prevention and clinical efforts need to be captured and tracked. MEDCOM will need to track the requirements for automating these reports and ensure that DA/DoD medical databases implement these requirements.

(2) Create a COSC/BH surveillance data repository and analysis center IAW DOD Directive 6490.2 and DOD Instruction 6490.3 – In order to better understand and ultimately prevent COSC/BH problems, data must be accurately collected, stored, and analyzed. The military has made great strides to database injuries (Lincoln, Smith & Baker, 2000), but has yet to adequately create or resource a BH surveillance system.

6. Develop a portable digitized BH medical record.

a. Immediate Implementation:

AOR BH consultants should publish documentation guidance – The MHAT found that BH documentation not only varied from location to location, but was often non-existent. Further, documentation was very difficult to transport between levels of care.

To overcome these discrepancies in the near-term, recommend theater BH consultants publish guidance to standardize the BH documentation and records management process. Specifically, directives should address what forms are used, how they are stored, how records are transferred to higher levels of care, and how to archive the records when the Soldier and/or medical unit redeploys.

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b. Future Implementation:

MEDCOM (in cooperation with Health Affairs and military agencies) should develop a field-deployable BH computerized patient record system – Long-term, MEDCOM needs to field a computerized record system (as a module to a larger medical system) that satisfies the needs of the behavioral healthcare system in the deployed environment. This would include a Soldier-portable medical record (like the "personal information carrier" or PIC).

PRESENTATION OF DATA THAT SUPPORTS THE FINDINGS

DATA FINDING #1: The closer Soldiers were treated to their units, the more likely they were to return to duty.

Data from COSC-WARS was analyzed to calculate the Soldier return to duty (RTD) rate for CJTF-7 Combat Stress Control units. Homegrown databases, that contained Soldier contact and evacuation information used by DMHS and the combat support hospitals (CSHs), were analyzed to calculate their Soldier RTD rates. The RTD rate was calculated by dividing the number of Soldiers returned to duty by the total number of Soldiers evaluated during the same time period. When the number of Soldiers who returned to duty was not readily available, it was calculated by subtracting the number of Soldiers evacuated from the total number of Soldiers evaluated during the same time period. The percentages of Soldiers who were treated for behavioral health problems and returned to duty (RTD) ranged from 4% to 97%, depending on the type of behavioral health unit they were treated in.

Table 2: OIF Return to Duty

Type of Unit	Unit	Dates	# Of Patients	# Of RTD	% RTD
Division Mental Health Section	[redacted]	30 Mar – 6 Sep 03	495	479	97
Combat Stress Control units	All CJTF-7 CSC units	26 Jul – 27 Sep 03	2008	1919	96
Combat Support Hospital (Iraq)	[redacted]	1 Apr – 31 Jul 03	301	209	69
Combat Support Hospital (Kuwait)		12 Mar – 1 Sep 03	229	26	11
Regional Medical Center	LRMC	1 Mar – 30 Sep	279*	10	3.6

* # Of charts reviewed

As a result of the high RTD, both units and Soldiers benefit. Units benefit from continued force sustainment and Soldiers avoid the stigma linked to evacuation for a behavioral health illness.

Reasons for a lower percentage of behavioral health Soldiers/patients returned to duty at the Combat Support Hospital and Medical Center are not clearly evident from this analysis. RTD may be lower because 1) hospital patients are more likely to have failed to benefit from outpatient interventions; 2) hospitals were not providing inpatient rehabilitation treatment and 3) hospitals have the means to initiate the patient's evacuation to the next echelon of care.

DATA FINDING #2: There is a lack of systematic training/education in the implementation of CSC Doctrine

Over half of the BH providers interviewed reported they did not know what COSC doctrine was, nor did they support it. Fifty (50%) percent also reported they had not received adequate training in combat stress prior to deployment. Results of the BH Survey indicated that 57% of the respondents agree that COSC was the best method of early intervention, but only 44% of the junior enlisted, 35% of the non commissioned officers (NCOs) and 45% of the officers agree that COSC doctrine is relevant to the current operation. Sixty nine percent surveyed agreed or strongly agreed they were well trained in the six functional areas of CSC prior to deployment. Over 50% of the BH providers interviewed stated the need for more intense training in COSC. Findings indicate that provider views vary on knowledge and execution of COSC doctrine. This was observed in theater, as CSC doctrine was integrated and utilized by some of the CSC units but was not followed by others. Providers who are not adequately trained in CSC doctrine may not implement CSC concepts or agree to the relevancy of CSC doctrine as a treatment method for Soldiers. One cannot determine relevancy of doctrine without fully understanding doctrine.

DATA FINDING #3: No standardized BH data collection methodology.

Each behavioral health activity in CJTF-7 was directed to enter their workload data into the COSC-WARS system and provide this information to the [redacted] Medical Brigade. However, the CSC units used COSC-WARS, the DMHSs input data into the DNBI database, and the CSH BH personnel utilized "homegrown" databases. Half (53%) of the BH units contacted in theater created and maintained their own "homegrown" database systems due to the reported shortfalls within the existing databases. These unofficial database systems were used to maintain additional caseload information and provide additional workload and Soldier/patient tracking information for the providers and also their commands. Maintaining multiple databases created additional work for the providers, but this did not detract from their desire to collect data that was valuable to their mission.

DATA FINDING #4: Although the number of BH personnel in theater was sufficient to provide coverage throughout the OIF AOR, there were areas in theater that lacked BH services.

To identify the adequacy of behavioral health support (see Appendix 8), the MHAT calculated the BH provider to Soldier population ratio for OIF and its collective areas of responsibility. The ratio was calculated by dividing the Soldier population of an area of responsibility by the number of behavioral health providers supporting that AOR.

As of September 2003, the OIF ratio was 1 behavioral health provider for every 851 Soldiers. In Iraq, the ratio was 1 provider for every 830 Soldiers; and in Kuwait, the ratio

was 1 provider for every 986 Soldiers. The ratios by area of responsibility ranged from no providers for 4,205 Soldiers, to one provider to every 673 Soldiers.

DATA FINDING #5: BH outreach efforts need improvement to better meet needs of Soldiers and line leaders.

BH personnel's perception of providing accessible care for Soldiers was different compared to the Soldiers who were surveyed. Ninety (90%) percent of the BH providers surveyed, agreed that Soldiers in their area of operation had good access to BH services. However, only 56% of the Soldiers surveyed reported knowing how to obtain behavioral health care in theater. Twenty-six (26%) percent of Soldiers reported it would be too difficult to get to behavioral health services. Of the Soldiers who screened positive for depression, anxiety, or traumatic stress, 27% reported receiving help at any time during the deployment from a behavioral health professional, general medical doctor, or chaplain. Of the Soldiers who reported interest in receiving help, only 32% reported receiving help during the deployment.

Sixty percent of the respondents to the Soldier well being survey identified command stigma (20%), difficulties traveling (20%) and leader/Soldier lack of knowledge about BH services and capabilities (20%) as the three top barriers to providing BH care in theater. Eight leadership interviews were conducted with battalion (n=7) and brigade (n=1) commanders from combat units and four CSM/1SG interviews were conducted as well. All the commanders and sergeants indicated that there was enough behavioral health services available and that they were generally happy with the support that they received. However, they reported that the time and resources it took to take a Soldier to see a mental health care provider was excessive. It would take one day or more and losing a minimum of an additional Soldier for transportation and security measures.

DATA FINDING #6: Lack of defined standards across the continuum of care from a garrison-based clinical model of practice to a COSC preventive model.

MHAT found there were operational and doctrinal differences among BH units. Interviews indicated providers were divided between the medical and preventive models as means of delivering BH services. The reported median time spent doing prevention activities was 39% compared to a reported median time of 60% for clinical treatment. Eighty-one (81%) percent of the psychiatrists and psychiatric nurses reported spending less than half of their time providing COSC prevention. The other BH providers only reported spending 50% of their time doing prevention activities. Without instruments to assess Soldier/unit needs, BH providers relied on familiar assumptions about needs of the community, and on familiar intervention models. Providers with COSC training favored preventive strategies to promote wellness in the population – sometimes to the exclusion of needed clinical interventions. Providers with medical or clinical backgrounds resorted to the "medical model" to evaluate and treat BH disorders in the population – to the exclusion of doing preventive outreach and interventions. The

spectrum of services must to be based on an assessment of the Soldier/unit needs. BH personnel who offer both clinical and preventive interventions provide a greater continuum of care for the Soldier.

DATA FINDING #7: Inconsistent communication and integration between BH providers and higher medical headquarters.

Thirty-seven (37%) percent of BH personnel reported receiving guidance and adequate supervision from their higher headquarters. Thirty-four (34%) percent reported not getting needed mission information and intelligence. Fifty-five (55%) percent of the BH officers were dissatisfied with their perceived level of input into operational planning, and only 19% of all BH personnel reported having input into the policies of their higher command.

DATA FINDING #8. Shortages of tactical radios and vehicles were an obstacle to conducting outreach.

Seventy-five percent (75%) of the BH officers interviewed in Iraq reported lack of radio, phone, and email access significantly impacted their ability to provide services to meet standards of care. Officers felt these shortages compromised Soldier confidentiality, and the ability to receive and give information to the Soldier or the Soldiers' unit. Shortages with SINGARS radios and vehicles made it difficult to meet convoy requirements and therefore significantly decreased a units' ability to provide out reach within its area of operation. Some teams were convoying without radios. The lack of email access also made it difficult to communicate with units about Soldier issues. This was further compounded by a significant number of respondents indicating their unit had few or no computers to carry out mission needs.

Only 49% of the BH providers surveyed agreed that they deployed with enough equipment to perform their mission. Officers often brought their own computers and supplies to meet mission requirements.

DATA FINDING #9: Forward-deployed BH units report a greater shortage of psychotropic medications than units located in the rear.

Dissatisfaction with the availability of psychotropic medication was particularly high between CSC and DMH units (57.1 & 66.7% respectively). For units at higher levels of care, particularly those with direct pharmacy support, the dissatisfaction with the availability of psychotropic medication was lower. Even so, 50% of psychiatrists and nurses at Combat Support Hospitals still reported dissatisfaction with psychotropic medication availability. Anecdotal reports indicated that psychotropic medications were in short supply during the initial phase of the conflict; that the range of available

medications was limited to a few selections; and that there was no process to make formulary recommendations to the pharmacy before the deployment occurred.

APPENDIX 1 (Summary of Behavioral Health Survey) to ANNEX B to OIF MHAT REPORT

INTRODUCTION

As part of the Mental Health Advisory Team's (MHAT) mission to evaluate the behavioral healthcare (BH) being rendered in theater, the MHAT devised an anonymous questionnaire for BH personnel.

FINDINGS

1. BH personnel are being utilized in their MOS/AOC.

Overall, 92% (93% of the officers, 89% of the NCOs, and 96% of the junior enlisted) reported they were being utilized in their MOS/AOC. Further, 83% felt they had been utilized appropriately.

2. BH personnel provide suicide prevention training prior to and during deployment.

52% of the active component and 32% of the reserve component BH personnel reported active involvement in suicide prevention prior to deployment. 81% of BH personnel report active participation in suicide prevention during the current deployment.

3. BH personnel believe Soldiers in their areas of operations have good access to BH services.

90% of the respondents believe Soldiers in their area of operations have good access to BH services. Only 2% disagreed with this assessment. Further, 83% of the respondents believed that the location of their base of operations was appropriate to their mission.

4. BH personnel generally have good communications with the commanders and unit ministry teams (UMT) in their areas of operation.

65% of the respondents reported good communications with local commanders and 71% reported good communications with their local UMT. Only 11% and 8% (respectively) felt they had particularly poor communications. And, 82% report that commanders in their area of operations actively request BH services.

5. BH personnel generally feel commanders readily accept return-to-duty (RTD) Soldiers back into their units.

77% of the respondents agreed that commanders readily accept RTD Soldiers back in their units. However, enlisted BH personnel (70%) were less positive about this than the BH officers (84%) ($F=4.95$; $p \leq 0.03$).

6. Many BH personnel are not well trained in combat and operational stress control (COSC).

31% of the BH personnel were either neutral or reported a lack of training in COSC functions prior to deployment.

7. Lack of needed psychiatric medications in theater (particularly early on in the operation).

Only 36% of the psychiatrists and nurses felt that there was an adequate supply of psychiatric medication in theater.

8. Many BH personnel lack guidance and support from higher headquarters.

Only 37% of the respondents reported getting guidance from their higher headquarters, and 34% report not getting needed mission information and intelligence. In addition, only 37% felt that they received adequate supervision and support from higher levels of care. There were no significant differences between components or ranks on this issue.

9. Possible lack of BH input into operational planning and policy.

Only 30% of the respondents felt they had adequate input into operational planning. More than half (55%) of the BH officers (and significantly more than the junior enlisted) were dissatisfied with their perceived level of input into the operational planning. Further, only 19% of all respondents felt that they had input into the policies of their higher command.

10. BH personnel spend significantly more time doing BH clinical activities than they spend doing COSC prevention activities.

Overall, the reported median time spent doing prevention activities was 39% compared to a reported median time of 60% doing clinical activities. Only 29% of the respondents reported spending more than half of their time doing prevention activities; on the other hand, 58% report spending more than half of their time doing clinical activities. Further, 81% of the psychiatrists and psychiatric nurses reported spending less than half of their time doing COSC prevention activities while only 50% of the other BH personnel report spending less than half of their time doing prevention activities.

11. Many Soldiers who were evacuated should not have been deployed due to prior mental health or other problems.

71% of the respondents felt that many of the Soldiers who ultimately were evacuated for behavioral health problems should never have deployed in the first place.

12. Many BH personnel do not believe that COSC doctrine is the best method of early intervention and/or do not believe it is relevant to the current operation.

Only 57% of the respondents felt that COSC doctrine is the best method of early intervention. The officers were more believing than the enlisted. Further, only 38% of all respondents felt that COSC doctrine was relevant to the current operation. Indeed, nearly half (47%) of the BH NCOs do not feel COSC doctrine is relevant to the current operation.

13. Command stigma, travel difficulties, and leader's/Soldier's limited knowledge of BH capabilities are the most identified barriers to BH care.

60% of the respondents identified command stigma (20%), difficulties traveling (20%) and leader/Soldier lack of knowledge about BH services and capabilities (20%) as the three top barriers to providing BH care in theater.

METHODS AND PROCEDURES

Study Sample.

A convenience sample of 116 (77%) of the 155 Army Behavioral Health (BH) providers and enlisted Mental Health Specialists in Kuwait and Iraq completed the survey between 29 August and 30 September 2003 at 15 locations around theater. Some BH providers traveled in from outlying areas to meet with the team, thus more than 15 unique locations are actually represented by the data.

On average, those completing the survey tended to be older (68% aged 30 or more), and higher ranking (45% officers) than the Army as a whole. Only 22% were junior enlisted Soldiers. Two-thirds (66%) had a college degree, and only two individuals (2%) had a GED in lieu of high school diploma.

The median time in service was 9 years, and the median time served with the current unit was only 12 months. 37% of the sample was female, and 38% were racial minorities. 56% were Active Component, 7% were National Guard, and 36% were Army Reserve Soldiers. 67% of the sample had not deployed prior to OIF. Table One shows the types of professionals represented in the survey.

Table 1: AOCs and MOSs Represented in the BH Survey

AOC/MOS	Description	Number	Percent of Respondents
65A	Occupational Therapists	5	4%
66C	Psychiatric Nurses	10	9%
60W	Psychiatrists	16	13%
73A	Social Workers	13	11%
73B	Clinical Psychologists	9	8%
91W/91WN3	Health Care Specialists	4	3%
91X	Mental Health Specialists	59	50%

Procedures.

The MHAT traveled throughout the Kuwait (CFLCC) and Iraq (CJTF-7) operational theaters and administered surveys and conducted interviews with BH personnel between 27 August and 30 September 2003. All BH personnel contacted by the MHAT were asked to complete the survey regardless of their current work assignment or unit.

MHAT personnel administered surveys. All participants were briefed on the mission of the MHAT and informed that the survey was both anonymous and voluntary. Nearly all BH personnel asked to complete the survey chose to participate.

Survey Instrument.

The MHAT members just prior to their deployment to theater constructed the survey. No standardized questions were utilized, though most of the questions were devised by consensus of the team members. The questions ranged on a variety of topics of interest to the MHAT mission, such as utilization, adequacy of care, balance of clinical vs. preventive activities, understanding of and compliance with COSC doctrine, involvement in suicide prevention and reporting activities, amount of support and supervision received, perceived stigma and barriers to mental health care, and resourcing deficits. A copy of the instrument can be found at Tab A.

TAB A: Behavioral Health Provider Survey

Behavioral Health Provider Survey

This survey is being done under the auspices of the Army Surgeon General's OIF Mental Health Advisory Team. The purpose of this questionnaire is to gather data about the current mental well-being of Soldiers in theater and the functioning of the mental health system in OIF/OEF. Your responses will not be linked to you as an individual.

Date: _____

Age: **18 – 19** **20 – 24** **25 – 29** **30 – 39** **40 or older**	Gender: **Male** **Female**	Race/Ethnicity: **Caucasian/White** **African American** **Hispanic** **Asian/Pacific Islander** **Other _____**	Highest Level of Completed Civilian Education? **GED** **High School Diploma** **College Graduate** **Professional Degree**
Grade/Rank: **E1 – E4** **E5 – E6** **E7 – E9** **O1 – O3** **O4 – O9** **WO1 – WO5**	Primary Component **Active Duty** **Reserve** **National Guard** **AGR** **PROFIS? Y / N** **USA / USN / USAF**	**How many** YEARS **have you been in the military? If less than 1 year, please mark "0"** **_____**	**For this deployment, indicate month you left for deployment?_____**
What is your current unit: **Division_____** **Brigade_____** **Battalion_____** **Company_____**	**How many** MONTHS **have you been with your current unit? _____**	**What is your AOC /MOS?_____**	**List your previous deployments_____** **_____** **_____** **___**

Behavioral Health Provider Survey

Please circle the number indicating the degree to which you agree or disagree with the statements below:
Circle 1 if you "Strongly Disagree", circle 3 if you neither agree or disagree, and circle 5 if you "Strongly Agree"

1. I was actively involved in suicide prevention prior to deployment.	1 2 3 4 5
2. I have been actively involved in suicide prevention during deployment.	1 2 3 4 5
3. What have been the most frequent stressors associated with suicide behaviors (gestures/attempts/ideas): 1_____ 2_____ 3_____ 4_____ 5_____	
4. Have there been any completed suicides in your AO?	Y / N
5. How many of the completed suicides had sought/received help from BH and/or UMT's _____	
6. Soldiers have good access to BH services in my AO.	1 2 3 4 5
7. What barriers to BH care exist in your AO? _____ _____	
8. I have good communications with: Lower Levels of Care	1 2 3 4 5
Higher Levels of Care	1 2 3 4 5
Other BH personnel	1 2 3 4 5
Unit Ministry Teams	1 2 3 4 5
Commander's	1 2 3 4 5
Other _____	1 2 3 4 5
9. My BH team has evaluated _____# of Soldiers each month with suicidal ideation: Month 1_____ Month 2_____ Month 3_____ Month 4_____ Month 5_____ Month 6_____ Month 7_____ Month 8_____ Month 9_____ Month 10_____	
10. My BH team has evaluated _____# Soldiers each month for suicide gestures or attempts: Month 1_____ Month 2_____ Month 3_____ Month 4_____ Month 5_____ Month 6_____ Month 7_____ Month 8_____ Month 9_____ Month 10_____	
11. What has been the monthly **%** of Soldiers with suicide-related behaviors referred by: Commanders_____ Unit Ministry Teams_____ Healthcare Providers_____ Soldier Self-referrals_____	
12. I routinely review lessons learned with Commanders after suicide attempts and completed suicides.	1 2 3 4 5
13. I routinely complete ASER's for suicide attempts and completions.	1 2 3 4 5
14. What has been the monthly RTD rate for Soldiers seen by your BH team? Month 1_____ Month 2_____ Month 3_____ Month 4_____ Month 5_____ Month 6_____ Month 7_____ Month 8_____ Month 9_____ Month 10_____	
15. COMMANDERS READILY ACCEPT RTD SOLDIERS BACK TO THEIR UNITS FROM BH.	1 2 3 4 5
PLEASE CONTINUE ON NEXT PAGE	

16. Please rank order the most frequent reasons that your patients are evac'd to higher Levels of Care? ___SUICIDAL ___HOMICIDAL ___PSYCHOSIS ___BIPOLAR ___PTSD ___OTHER ANXIETY D/O ___OTHER AXIS I ___ADMINISTRATIVE ___AXIS II ___OTHER _____; ___ OTHER _____; ___OTHER _____	
17. There has been sufficient holding capability for BH patients in my AO.	1 2 3 4 5
18. Patient transport among levels of care in my AO has been adequate.	1 2 3 4 5
19. The location of my BH team has been appropriate for my mission.	1 2 3 4 5
20. I was well trained in the six functional areas of Combat and Operational Stress Control prior to deployment.	1 2 3 4 5
21. Are you currently working in your BH job?	Y / N
22. On average, how many hours have you worked per week in the last month?	
23. On average, how many hours have you worked **in your MOS/AOC** per week in the last month?	
24. I have been appropriately utilized as a BH provider.	1 2 3 4 5
25. There has been adequate availability of appropriate psychiatric medications.	1 2 3 4 5
26. What medications have been needed but not available _____; _____; _____; _____; _____; _____; _____; _____	
27. Laboratory services have been sufficiently available.	1 2 3 4 5
28. What labs have been needed but not available _____; _____; _____; _____	
29. What clinical services have been needed but not available _____; _____; _____;	
30. My BH team deployed with its required personnel.	1 2 3 4 5
31. My BH team deployed with its required equipment supplies.	1 2 3 4 5
32. Commander compliance with Command Directed Evaluations is at the same level as prior to deployment.	1 2 3 4 5
33. My team receives guidance/taskings from my higher HQ.	1 2 3 4 5
34. My team receives requests for assistance from units in my AO.	1 2 3 4 5
35. My team receives information and intelligence relevant to our mental health mission.	1 2 3 4 5
36. My team has input into operational planning.	1 2 3 4 5
37. My team has input into my higher HQ Command policies.	1 2 3 4 5
38. My team is able to maintain communication with detached personnel.	1 2 3 4 5
39. What **%** of your time is typically spent in _____ Prevention activities; _____ Clinical activities	
40. Please list your major prevention activities _____; _____; _____; _____; _____; _____; _____; _____;	
PLEASE CONTINUE ON NEXT PAGE	

41. Supervision and support from higher Levels of Care has been adequate.	1 2 3 4 5
42. I am able to provide treatment on an outpatient basis.	1 2 3 4 5
43. I am able to monitor treatment progress for my patients.	1 2 3 4 5
44. Many of the Soldiers who we evacuated should not have been deployed due to prior mental health or other problems.	1 2 3 4 5
45. I believe that the combat/operational stress doctrine is the best method of early intervention.	1 2 3 4 5
46. The current combat/operational stress control doctrine is relevant to the current operations.	1 2 3 4 5
For the items below, please circle the number that indicates how often you provide the following actions. **1= Never; 2 = Seldom; 3 = Sometimes; 4 = Often; 5 = Always**	
47. Our team provides classes and/or briefings to units to help them cope with the stresses of deployment and/or combat.	1 2 3 4 5
48. When visiting units, our team provides informal counseling.	1 2 3 4 5
49. Our team typically diagnoses a Soldier's condition during the first visit.	1 2 3 4 5
50. After a critical event, our team monitors leaders' actions to insure Soldiers' physical needs are met (food, sleep, hygiene, etc.).	1 2 3 4 5
51. Members of our team facilitate debriefings following critical events.	1 2 3 4 5
52. Our team assists unit leaders to integrate replacements following battle losses.	1 2 3 4 5
53. Usually, our team refers symptomatic Soldiers to a higher level of care.	1 2 3 4 5
54. Our team rules out medical causes for Soldier's mental symptoms.	1 2 3 4 5
55. Our team treats distressed Soldiers with family or home front problems as mental disorders.	1 2 3 4 5
56. Our team ensures that each Soldier receives a DSM-IV diagnosis.	1 2 3 4 5
57. Our team subdues and restrains an agitated Soldier by verbal assurances and reorientation.	1 2 3 4 5
58. Our team trains to safely control behaviorally disruptive Soldiers who pose a threat to themselves or others.	1 2 3 4 5
59. Our team provides 24 or more hours of rest, food, hygiene, sleep, and work and relaxing activities for Soldiers overwhelmed by combat or operational stress.	1 2 3 4 5
60. Our team routinely provides medications to Soldiers to help them deal with combat and operational stressors.	1 2 3 4 5
61. Our team provides a program of treatment (e.g., structured work and multi-modal therapies) to return Soldiers to duty that couldn't return to duty after 3 days.	1 2 3 4 5
62. Our team routinely conducts medical consultations to establish a treatment plan.	1 2 3 4 5
THANK YOU FOR COMPLETING THE SURVEY	

APPENDIX 2 (Summary of Primary Care Survey) to ANNEX B to OIF MHAT REPORT

INTRODUCTION

As part of the Mental Health Advisory Team's (MHAT) mission to evaluate the behavioral healthcare (BH) being rendered in theater, the MHAT devised an anonymous questionnaire for primary medical care personnel. These personnel were doctors, physician assistants, nurses, medics serving in line units, forward support medical companies, combat support hospitals, and clinics.

FINDINGS

1. Primary care personnel generally refer Soldiers with BH issues to a BH provider.

80% of the respondents refer their patients with BH issues to a BH provider. 20% will refer them to a chaplain, and 10% may treat them directly. This varied by rank. Enlisted primary care personnel never treated patients with BH issues themselves, while 16% of the officers would treat them directly.

2. Primary care personnel think units stigmatize their Soldiers with BH problems.

89% of the respondents reported that line units often or always accept Soldiers RTD with medical problems. However, only 53% of the respondents reported that line units often or always accept Soldiers RTD with BH problems. While 55% of the junior enlisted and 57% of the officers perceive that line units often or always accept Soldiers RTD with BH problems, only 39% of the primary care NCOs felt they would be accepted back.

METHODS AND PROCEDURES

Study Sample.

A convenience sample of 154 Army primary medical care providers and enlisted Health Care Specialists in Kuwait and Iraq completed the survey between 29 August and 29 September 2003 at 21 locations around theater.

On average, those completing the survey tended to be older (67% aged 30 or more), and higher ranking (55% officers) than the Army as a whole. Only 25% were junior enlisted Soldiers. Two-thirds (68%) had a college degree, and only six individuals (4%) had a GED in lieu of high school diploma.

The median time in service was 9 years, and the median time served with the current unit was only 8 months. 27% of the sample was female, and 33% were racial minorities. 70% were Active Component, 23% were National Guard, and 7% were Army Reserve Soldiers. 62% of the sample had not deployed prior to OIF. Table One shows the types of professionals represented in the survey.

Table 1: Professions Represented in the Primary Care Survey

Description	Number	Percent of Respondents
Physicians	34	22%
Physician Assistants	24	16%
Nurses	18	12%
Health Care Specialists	69	45%
Other	9	5%

Procedures.

The MHAT traveled throughout the Kuwait (CFLCC) and Iraq (CJTF-7) operational theaters and administered surveys to primary care personnel between 27 August and 30 September 2003. As the MHAT surveyed Soldiers in line units and BH personnel in medical units, they also surveyed available primary care personnel organic or attached to these same medical or line units. In most cases, a convenience rather than a blank sample was gathered at each unit/site.

MHAT personnel administered surveys. All participants were briefed on the mission of the MHAT and informed that the survey was both anonymous and voluntary. Nearly all primary care personnel asked to complete the survey chose to participate.

Survey Instrument.

The MHAT members just prior to their deployment to theater constructed the survey. No standardized questions were utilized, though most of the questions were devised by consensus of the team members. The questions range a variety of topics of interest to the MHAT mission, such as utilization, handling of mental health patients, referral methods and locations, adequacy of BH care, holding capacity for COSC Soldiers, and their sense of perceived stigma and barriers to mental health care. A copy of the instrument can be found at Tab A.

TAB A: Primary Care Survey

PRIMARY CARE SURVEY

This survey is being done under the auspices of the Army Surgeon General's OIF mental health advisory team. The purpose of this questionnaire is to gather data about the current mental well-being of Soldiers in theater and the functioning of the mental health system in OIF/OEF. Your responses will not be linked to you as an individual.

Date: _____

Age: **18 – 19** **20 – 24** **25 – 29** **30 – 39** **40 or older**	Gender: **Male** **Female**	Race/Ethnicity: **Caucasian/White** **African American** **Hispanic** **Asian/Pacific Islander** **Other _____**	Highest Level of Completed Civilian Education? **GED** **High School Diploma** **College Graduate** **Professional Degree**
Grade/Rank: **E1 – E4** **E5 – E6** **E7 – E9** **O1 – O3** **O4 – O9** **WO1 – WO5**	Primary Component **Active Duty** **Reserve** **National Guard** **AGR** **PROFIS? Y / N** **USA / USN / USAF**	**How many** YEARS **have you been in the military? If less than 1 year, please mark "0" _____**	**For this deployment, indicate month you left for deployment?_____ ___**
What is your current unit: **Division_____** **Brigade_____** **Battalion _____** **Company_____**	**How many** MONTHS **have you been with your current unit?** **_____**	**What is your AOC /MOS?_____**	**List your previous deployments_____** **_____** **_____** **_____**

1. On average, how many **hours** have you worked **per week** in the last month? _____

2. On average, how many **hours** have you worked **per week** in your MOS/AOC in the last month? _____

3. On **average**, how many patients do you see in a **week**? _____

4. On **average**, what **percentage** of these patients has mental health issues **per week**? _____

5. What **percentage** of these mental health patients do you RTD? _____

6. What do you do with Soldiers who have mental health issues?

7. To whom do you typically send a Soldier for mental health issues (Circle One)?

I treat them Unit leadership Chaplain Mental health (Div) CSC

CSH/hospital Other _____

8. What do you do with Soldiers who make suicide threats?

I treat them Unit leadership Chaplain Mental health (Div) CSC

CSH/hospital Other _____

9. What do you do with Soldiers who make suicide attempts?

I treat them Unit leadership Chaplain Mental health (Div) CSC

CSH/hospital Other _____

10. What do you do with Soldiers who make homicidal threats?

I treat them Unit leadership Chaplain Mental health (Div) CSC

CSH/hospital Other _____

11. Do you have an SOP for managing suicidal Soldiers (Circle)? Yes No Don't Know

12. Who are the mental health personnel (units or individuals) that you interact with?

13. Do these personnel provide sufficient support? If not, what additional support do you need to help your Soldiers with mental health issues?

14. Do you have any holding capacity for Soldiers experiencing combat/operational stress?

Yes No

If so, what is your maximum capacity? _____

15. How accepting are the line units to having their Soldiers returned to them after being treated for a mental health problem (Circle One)?

Never Seldom Somewhat Often Always

16. How accepting are the line units to having their Soldiers returned to them after being treated for a medical problem (Circle One)?

Never Seldom Somewhat Often Always

17. Do you document your treatment of MH patients, and if so, where does this documentation go?

18. Additional Comments?

Thank You!

APPENDIX 3 (Summary of Unit Ministry Team (UMT) Survey) to ANNEX B to OIF MHAT REPORT

INTRODUCTION

As part of the Mental Health Advisory Team's (MHAT) mission to evaluate the behavioral healthcare (BH) being rendered in theater, the MHAT devised an anonymous questionnaire for unit ministry team (UMT) personnel. These personnel were chaplains and chaplain assistants serving in line units, forward support medical companies, and combat support hospitals.

FINDINGS

1. Many UMT personnel are not trained in the Army's suicide prevention program.

Nearly half (46%) of the UMT personnel have not been trained in the current Army suicide intervention techniques; the Applied Suicide Intervention and Skills Training (ASIST) or in the Army's "Menningers" course for UMTs. Significantly more active component UMT personnel have been trained in ASIST/Menningers (74%) than have reserve component UMT personnel (34%).

2. Many UMT members conducted suicide prevention training for their units prior to deploying.

69% of the respondents stated they had conducted suicide prevention training for their units prior to deployment. Of the 31% who did not, 42% stated they joined the unit following deployment, 19% stated that someone else had done the predeployment briefings for the unit, and 12% stated that they did not do it predeployment because they do it annually or quarterly. Only 15% said that they did not do it because they were too busy or didn't have command support. Most of the training given was given that the company (46%) or battalion (34%) level.

In addition, most (77%) UMT members felt competent in providing a quality unit suicide prevention program. Only 4% reported not feeling competent to do so. However, the enlisted members and those from the reserve components felt significantly less competent than their officer or active component counterparts.

3. Some commanders have not taken ownership of or are not resourcing their unit's suicide prevention program.

While 56% of the respondents felt the commander was taking ownership and resourcing the unit suicide prevention program, 16% felt the commander was clearly not taking ownership of the program; 28% of the respondents felt the commander was only

lukewarm about the unit suicide prevention program. Enlisted UMT members and those from the reserve components feel significantly stronger that their commanders are not taking ownership and/or resourcing the suicide prevention program compared with their officer or active component counterparts.

4. Many chaplains do not feel their relationship with their local BH providers is functional.

While only 16% report a poor functioning relationship, only 55% feel they have a good one. Further, the enlisted UMT members and those from the reserve components report a significantly poorer relationship with their local BH provider(s) than their officer or active component counterparts.

5. Uncertain redeployment dates, family separation/problems, and command/leadership problems are the three main issues impacting Soldiers.

Table 1: UMT's Perception of the Top Five Issues Impacting Soldiers

Issue	Number	Percent of Respondents
Uncertain Redeployment Dates	53	56%
Family Separation or Family Problems	42	45%
Command/Leadership Relations	27	28%
High OPTEMP / Work Conditions	21	22%
Communication with Home	19	20%

6. Better logistical support, certain redeployment dates, and having units fully staffed with trained UMT members were the top three things that would best impact the UMT mission.

26% of the respondents identified logistical shortages as the single biggest issue impacting their UMT mission. UMT members identified the need for items such as computers, printers, internet access, phone access, a vehicle, tentage, and religious education/family support materials.

14% of the respondents identified having a certain redeployment date as most helpful to their UMT mission. 13% identified having their units fully staffed with personnel who are trained and spiritually committed. One division chaplain noted he was short 7 battalion chaplains at the time of the survey.

7. UMT members identified other chaplains, family, and other Soldiers as their primary source of personal support.

38% of the UMT members reported another chaplain as a source of support, 25% identified family as a source of support, and 21% reported other Soldiers as a source of support. 13% of the UMTs identified God as a source of personal support.

METHODS AND PROCEDURES

Study Sample.

A convenience sample of 94 UMT members (Army chaplains and enlisted chaplain assistants) in Kuwait and Iraq completed the survey between 29 August and 25 September 2003 at 23 locations around theater. In addition, a number of UMT members were canvassed during routine UMT training meetings in both Kuwait and Iraq, thus more than 23 locations are actually represented.

Two-thirds (66%) of the respondents were commissioned chaplains, 15% were chaplain assistant NCOs, and the rest (19%) were junior enlisted chaplain assistants. Of the officers, about half (52%) were field grade officers. 52% were Active Component, 12% were National Guard, and 35% were Army Reserve Soldiers. Further, active component officers were significantly junior in rank to the reserve component officers. Time in theater ranged from 14 days to 365 days, with a median of 159 days.

Table 2 shows the types of units the respondents supported in theater.

Table 2: Types of Units Supported by UMT Personnel

Description	Number	Percent of Respondents
Combat Units	26	28%
Combat Support Units	29	31%
Combat Service Support Logistics Units	28	30%
Combat Service Support Medical Units	11	12%

Procedures.

The MHAT traveled throughout the Kuwait (CFLCC) and Iraq (CJTF-7) operational theaters and administered surveys to UMT personnel between 29 August and 25 September 2003. As the MHAT surveyed Soldiers in line units and BH personnel in medical units, they also surveyed available UMT personnel organic or attached to these same medical or line units. In most cases, a convenience rather than a blank sample was gathered at each unit/site.

Surveys were administered by MHAT personnel. All participants were briefed on the mission of the MHAT and informed that the survey was both anonymous and voluntary. Nearly all UMT personnel asked to complete the survey chose to participate.

Survey Instrument.

The MHAT members just prior to their deployment to theater constructed the survey. No standardized questions were utilized, though most of the questions were devised by consensus of the team members. The questions range a variety of topics of interest to the MHAT mission, such as the quality of the suicide prevention programs within units, the relationship UMT members have with BH personnel, and what UMT members perceive as the major issues impacting Soldiers. A copy of the instrument can be found at Tab A.

TAB A: Unit Ministry Team (UMT) Survey

OIF UMT SURVEY

The survey is being done under the auspices of the Army Surgeon General's OIF mental health advisory team. The purpose of the questionnaire is to gather data about the current mental well-being of Soldiers in theater and the functioning of the mental health system in OIF/OEF. Your responses will not be linked to you as an individual.

Your Rank: _____ Your Component (Circle): Active Reserve Guard

Date: _____ Date You Arrived in Theater (this deployment): _____

Type of Unit Supported: Combat Combat Service Support (Medical)

Combat Support Combat Service Support (Logistics)

1. Have you received either Menninger or ASIST training (circle)? Yes No

2. How competent do you feel in providing a quality suicide prevention program for your unit (circle):

Very Good 1 2 3 4 5 6 7 8 9 Very Poor

3. Did you conduct pre-deployment suicide prevention briefings for the unit? Yes No

a. If Yes, at what level? Squad Platoon Company Battalion Other

b. If No, why not? _____

4. How well do you feel your commander has taken ownership of the program and used command influence to resource it?

Extremely well 1 2 3 4 5 6 7 8 9 Not at all

5. How functional would you say your relationship is with your local mental health care provider(s)?

Extremely functional 1 2 3 4 5 6 7 8 9 Very Poor

6. What are the three biggest issues that impact your Soldiers (use back if needed)?

7. What one think would make the biggest positive impact on your unit ministry mission?

8. Who do YOU turn to for personal support?

APPENDIX 4 (Summary of Behavioral Health Interviews) to ANNEX B to OIF MHAT REPORT

INTRODUCTION

Face to face interviews with behavioral health professional (officer) and paraprofessional (enlisted, NCOs) personnel from CFLIC (Kuwait) and CJTF-7 (Iraq) were conducted to obtain level of perspectives on the delivery, resources and problems encountered providing mental health/behavioral health care in a combat operational theater. The professional behavioral health field is comprised of five specialties: psychiatry, psychology, social work, psychiatric nursing, and occupational therapy.

KEY THEMES

1. Resource issues impact delivery and quality of care.

Professional and paraprofessional behavioral health providers listed the lack of or absence of communication devices (telephone, SINGARS radio), vehicles, and computers as a key obstacle in providing quality care.

2. Provider views vary on services offered for their area.

Providers are divided between the medical model and prevention as a means of delivering services to Soldiers.

3. Provider views vary on knowledge and execution of COSC doctrine.

Over half of the providers indicated they either did not know what the COSC doctrine was or they did not support it.

4. Providers indicate a need for training in COSC.

Over half of the professional and paraprofessionals' interviewed stated they had not received adequate training in combat stress prior to deployment. Providers stated the need for more intense training in COSC.

APPROACH

Face-to-Face Interviews.

Members of the MHAT team conducted all interviews. Forty-one interviews were conducted at fourteen different locations throughout the Kuwait and Iraq area of operations with the following group composition:

Field grade	12	(29%)
Company grade	15	(37%)
NCO	7	(17%)
Junior Enlisted	7	(17%)

Themes/Questions.

Prior to all interviews, key themes and specific questions were determined that every MHAT interviewer would attempt to address. All individuals were asked the same questions. Below are the specific themes and questions for all interviews.

Themes: Resources, Soldier problems, clinical activates, documentation, and knowledge of Combat Operational Stress Control (COSC). Interview questions included: (1) what resources do you lack to conduct your mission? How does it impact? (2) What are the most frequent Soldier problems your team/unit encounter? (3) What have been your unit's/team's most effective prevention activities? How do you know? (4) What have been your unit's/team's least effective prevention activities? How do you know? (5) What have been your unit's/team's most effective clinical activities? How do you know? (6) What have been your unit's team least effective clinical activities? How do you know? (7) Have you had to change your SOP's for this deployment? If so, why? (8) How does your unit/team respond to Critical Events (i.e. Soldier casualties, suicides, accidents)? (9) Is your clinical documentation: electronic/paper/none//stored with you/stays with Soldier. (10) What do you think are your unit's/team's most effective suicide prevention activities? (11) How do you manage Soldiers who are dangerous to self and/or others? (12) How do you monitor clinical activities? (13) How does your unit/team implement the six functional areas of COSC? (14) How well did the combat/operational stress guidelines you read or were taught apply to the current operations? (15) How could the guidelines or training be improved? (16) Describe your processes for maintaining patient confidentiality. (17) Have you provided care to detainees/civilians? If so, have you had adequate training and resources for this?

Procedures.

All interviews began with member of the MHAT interview team introducing him/her self and describing the purpose and objective of the interview. Confidentiality and anonymity were guaranteed in order to encourage candid and honest discussion. Thus, no names of any of the interviewee's were recorded. All interviews lasted approximately 60 minutes.

RESULTS

Enlisted Behavioral Health Specialists (91X) in Iraq

There were ten NCOs and junior enlisted in the CJTF-7 AO, three females and seven males. There were another eight Soldiers identified in the "comments" section as being present for several of the individual interviews. Only two Soldiers identified having prior deployment experience. Under the heading 'resources', several respondents indicated manning was an issue for their organization. Several respondents from the same unit indicated that they came to the theater short a few people and have since lost an additional five personnel. (100% manned equals 23). This shortage coupled with additional duties tasked for the junior enlisted created problems in the unit delivering services to other units. " We are tasked out with many things in the AO and are not able to get our main job's done. KP, guard duty, and other duties keep us out of the job 2-3 days a week….it impacted the prevention team make-up and we are short one Prevention Team. At least one member of each of the five separate behavioral health organizations represented indicated that the units' computers were an issue. Several indicated the computers were not configured to meet the unit needs and required reconfiguration to accomplish the mission. Several units also indicated that they did not have computers to provide their teams (most BH units had teams spread out around the theater) and therefore the teams were not able to enter into and report data on the COSC-WARS reporting system. Teams also were not able to enter patient/client data electronically. Communications was an issue for most respondents. Several reported only one SINGARS for their unit "Went 1 ½ months with no communication with our outlying prevention teams." The limited number of SINGARS radios also presented problems for unit ability to convoy (convoys require three vehicles, two vehicles with SINGARS). Several individuals indicated their unit did not have DSN/telephone capability. This created two problems from their perspective; units served could not contact them for 'requests for service', and, a compromise of patient confidentiality (team members would have to borrow the use of another units phone, often without the ability to speak in private). Only one member reported the absence of medications as a problem for his unit. Half of the individuals indicated they did not have and adequate number of vehicles to carry out their mission. Several members also indicated that the

vehicles were not adequately armored to provide protection for the teams while on the road and were concerned about the safety of their team members.

Two issues were reported by at least half of those interviewed as frequent concerns of Soldiers. (1) Family issues, i.e.; money health, infidelity, or loneliness. (2) Conflicts with leadership. Several 91Xs reported that Soldiers were voicing concerns about safety while convoying, "…service members are scared on convoy(s)." "…IEDs, RPG and ambushes are the major concerns in reference to Soldier well being." Other frequent issues included; prior behavioral health issues resurfacing, deployment length and uncertain return home date, symptom complaints (sleep, irritability, depressed), battle fatigue and combat operational stress issues. Other concerns reported by at least one Soldier: "homicide" (specifics are not available), "handling human remains", and lack of knowledge in combat operational stress procedures by leaders and Soldiers (it was unclear if this was a behavioral health provider shortcoming or the units serviced)

The most frequently reported effective prevention activity listed by 91Xs was "walk about and sector sweeps" (going into another units AO and engaging with Soldiers). Soldiers (91X) involved in these activities report; lower rates of use for mental health services in their AO, higher level of recognition on return to the unit serviced, and increased acceptability of mental health services by Soldiers and command. Interviewees also reported psycho-educational classes and debriefing as effective interventions. Only two Soldiers, both from the same behavioral health organization, reported "walk about" and classes, as ineffective, preferring to utilize a garrison style clinic approach. (These two Soldiers were members of a unit whose commander did not support any MH functions in theater other than clinical operations).

Least effective prevention activities were limited to specific class offerings, i.e.; " What to do when you get a dear John letter" or "guided imagery". One Soldier who identified "walk about" as most effective also indicated it as least effective, " units blow us off until they need us." One Soldier indicated OT, as a function was ineffective but related the failure to lack of OT supplies to carry out a successful mission.

Most Soldiers interviewed agreed that one on one intervention was their most effective clinical intervention. Those Soldiers endorsing one to one felt it was related to the ability to provide a "safe and confidential ' place for Soldiers to tell their problems. Nearly half of the 91Xs interviewed endorsed medication management and psycho-educational classes as an effective clinical operation.

One Soldier felt the "Fitness Center" run by the unit was very effective at returning Soldiers to duty.

There was no strongly endorsed "least effective clinical " function reported. Individuals reporting problems indicated the following: getting Soldiers into the CSH for holding, intervening too soon after a crisis ("Maybe we should wait the 48-72 hours as based on doctrine"), switching back and forth between prevention and clinical activities, Soldiers "bored with suicide awareness training", inability to provide consistent follow-up with the same provider, and using restoration as a treatment intervention. The

interviewee stated that Soldiers placed in restoration failed because the Soldier knew that the next step was hospitalization and then “a ticket home”.

Seventy percent of the 91Xs interviewed indicated either they were not aware any SOP for their unit or did not respond to the question of an SOP. Of the three 91Xs responding, all indicated they felt FM 8-51 did not adequately address the problems they viewed as important. One Soldier indicated that FM 8-51 and HQ SOPs were too rigidly applied and tied the hands of Soldiers to do the job effectively. The collective responses of the 91X indicate possible problems with; clearly understanding FM 8-51doctrine or ambiguities within doctrine, insufficient supporting SOPs for theater events, or a failure to embrace doctrine as a means of addressing combat operational stressors.

All respondents reported Critical Event Debriefing as non-problematic. Only two Soldiers from the same organization reported the ability to do documentation electronically. One solder reported his unit had run out of forms and had no means available to copy or reproduce additional forms. All individuals indicated they gave a copy of the intervention activity to the Soldier and kept a record for the unit. Unit plans for managing records after returning to home station were not clear. One Soldier indicated his unit planned to burn all records.

Soldiers interviewed indicated that suicide education classes were their units’ most effective intervention for suicide. They also listed as safety contracts and unit watch as other successful intervention practices. They varied on responses for management of dangerous patients. Most responded that dangerous Soldiers were referred to the CSH for possible hospitalization. Some indicated UCMJ action, removal of weapons or limited access to weapons as intervention steps.

Less than half of the 91Xs interviewed indicated that they had knowledge of or used COSC functions/doctrine. Of the four Soldiers who indicated they knew and used doctrine, two indicated it was either “not appropriate for this battle” or applied it too rigidly, “We only do prevention” Two Soldiers from the same unit have consistently responded throughout the interview process that their unit only does clinical functions and that CSC does not apply to their mission in the theater and that it does not work when they have attempted to use it. These two Soldiers have also indicated that their unit did not provide or emphasize CSC training in the pre-deployment phase of the unit. Several Soldiers indicated that they have never received training in combat operational stress guidelines since entering into their field one Soldier indicated he had only worked in TDA assignments.

The majority of 91Xs felt training in COSC were either non-existent or grossly inadequate to prepare them for their mission. Several indicated that while in the garrison setting the emphasis is on “other” duties, i.e., motor stables, etc., at the expense of learning their MOS duties and functions. The problem was severe enough for several of them that they felt they did not know how to adequately do their job in theater. Many of the Soldiers requested that more time and more thorough training be given to them.

All Soldiers indicated that confidentiality issues were discussed with Soldiers seen in their areas. Several indicated that any files maintained by their organization were kept secured. With respect to intervening with civilians, only two responded that they had performed any interventions. No solider acknowledged having any training in dealing with civilians, either allies or Iraqi.

Additional comments included; “there is no place for me to go when I need someone to talk to.” “Command had lectured them on sucking it up and doing the right thing until the Commander learned we weren’t going home for sometime. Then they broke down and cried, after this things loosened up a bit…” This comment was made in the context of the unit’s productivity for seeing Soldiers.

Behavioral Health Officers in Iraq

A total of twenty-one company grade and field grade mental health officers were interviewed. Seventeen were male, four female, including one female officer from the USAF. Nine officers were field grade rank. The officers represented eleven different units located at twelve separate locations. The full range of behavioral health specialties was represented. Three officers indicated they had previous deployment experience.

Approximately 75% of the officers responded that communications problems; i.e., phones, SINGARS, and email access, significantly impacted their ability to provide services that would meet standard of care. Officers felt these shortages compromised Soldier confidentiality, and the ability to receive and give information to the Soldier or the Soldiers’ unit. “Command is not providing input because they can’t call us to discuss the Soldier. Soldiers just show up cold.” The only USAF officer seeing Army Soldiers stated, “ No way to contact Army leaders about the Soldiers referred to me from the [redacted] by their medical teams and chaplains. The Army units lack phones and email. They talk of a ‘green phone’, but I don’t know what it is or how to access it. The impact is, I can’t hear the leaders’ side of what the Soldier tells me, or advise them on how to help the Soldier.” Shortages with SINGARS radios made it difficult to meet convoy requirements and therefore significantly decreased a units’ ability to do out reach within its AO. The lack of email access also made it difficult to communicate with units about Soldier issues. This was further compounded by a significant number of respondents indicating their unit had few or no computers to carry out mission needs. “I spent over a thousand dollars of my own money to get the needed supplies for this mission. I bought my own printer.” Another officer indicated the shortage of email access/computers necessitated his using his own personal “MWR email time allocation” to do official business such as mail reports to higher headquarters, or communicate with units about a Soldier. Other concerns reported that impacted mission capability included shortages or no access to medications, a particular problem for CSC units (medication is not listed in their MTOE, however they see sufficient numbers of Soldiers requiring medication maintenance). The lack of vehicles also reduced the ability to successfully do out reach within the units AO. Staffing shortages caused when the CSHs did split operations impacted the ability to provide a NP unit at the CSH. Several providers felt this impacted their ability to hold

patients or do effective administrative evaluations ultimately creating premature or excessive evacuation from theater.

Nearly two thirds of those interviewed listed home front issues, i.e.: family problems, infidelity, missing family or key events, money, etc, as a frequent complaint for Soldiers. Approximately half listed; leadership, unknown return home or length of deployment, problems with peers or unit, prior psychiatric problems, and combat operational stressors as frequently heard Soldier concerns. Other problems listed included; occupational, fatigue from duties, family support groups, and Soldiers with self-harm incidents.

Half of the officers indicated that "walk about" or presence in the unit was their most effective method. "We know because patients and commanders are willing to convoy two hours to see us." "Soldiers coming to me in D-Fac." Several units indicated they did not do or see prevention as being their mission, "We don't do prevention, but focus on mental health care." "No proactive outreach program." Half of the officers also endorsed psycho-education classes as being very effective. ""Prevention classes, actually showed decrease in cases after classes outreach to units." Several officers indicated unit surveys or an assessment of the unit was beneficial and well received by commands. "After providing a unit assessment, we would print up a document with assessment findings and recommendations. This was well received by commands."

The majority of respondents indicated no response or no problem for "least effective" prevention activity. One officer indicated the absence of medication up to July created problems with preventing further psychiatric complications. "No meds available – particularly for Soldiers needing refills. We only started to get meds in July (at the CSH). Prior to this, we had to send troops all the way to Kuwait on C-130 hops to get their meds refilled. We need to deploy with a med chest full of psych meds." The Air Force mental health officer indicated problems with communicating with officers and getting them to understand the issues. " The Army leaders seem to understand battle stress, but not family problems or anything else. In the Air Force, no commander has ever second-guessed me. Here, with the Army, their reaction is "Suck it up; it's a war…. I wish I could contact the commanders and get them to be more supportive." Other responses included; "we don't do formal CEDs, we abandoned that.", "Stress classes become 'complaining sessions'.

Clinical activities, either successful or unsuccessful, did not elicit overwhelming response for any single factor. There were a total of four favorable responses for one to one intervention and psycho-education classes. Other positive clinical activities eliciting 3 or fewer responses are: presence/availability, CED, fitness program, or traditional style mental health services. Negative clinical activities with fewer than three responses included: "clinic mentality", psychotherapy, "holding patients too long in theater", set schedule, and pressure to provide a diagnosis.

Responses from participants on changing SOPs included eight who said they had changed their SOPs, and six who said they either did not have an SOP or they

were not aware of having an SOP for their unit. Reasons for changing SOPs included: changing operational environment, problems between CSC and DMH, flexibility or rigidity in the application of prevention vs. restoration activities. One officer indicated a change was needed to counter the impact of the 'MRI CSH' doctrine change. Apparently the MRI CSH was resistant to admitting actively suicidal patients. This resistance to admitting forced the mental health unit to provide a means of keeping and watching the Soldier, something the unit was not resourced for. Another officer indicated a need to write an SOP to counter units sending home Soldiers for home front stressors without seeking mental health guidance first. This BH officer was concerned about the possibility of another Ft. Bragg type occurrence.

All officers responding indicated they have been doing CEDs and felt they were favorably received by command. Several indicated they had modified the application to meet their perceived needs.

Only three officers indicated they could keep records electronically. Interviewees were evenly divided between sending the record exclusively with the Soldier or giving the Soldier a copy and maintaining a copy with the BH unit. Over half indicated they sent a copy with the Soldier when the Soldier was air evacuated. Several officers indicated they had not kept any written record of prevention interactions though they indicated they had concerns about 'standard of care' or licensure issues'. Several officers indicated a shortage of paper made it difficult to provide documentation.

Slightly less than half of the behavioral health officers indicated suicide prevention classes as their most effective intervention. Several indicated they did not do suicide prevention because they viewed it as a chaplain program. "We have also been instructed not to do suicide prevention programs (because it was the chaplains). Three officers from other units indicated they did suicide prevention because the chaplain in their AO was not doing suicide prevention or did it poorly. Responses for intervention to dangerous Soldiers included taking the Soldiers weapon away (8 respondents), unit watch (3 respondents) and talk therapy (6 respondents).

Half of the behavioral health providers indicated they monitored clinical outcomes through follow-ups with Soldiers. Most indicated this was a difficult task because of theater constraints. Several officers indicated they could not or did not measure outcomes because Soldiers did not return to them or could not be located after the provider saw the Soldier. Several indicated in this section of the interview and other sections of the interview that Soldiers sent to the hospital were often lost through the evacuation system. Providers attributed this loss to the Soldier's knowledge that once he/she made it to the hospital, they had a ticket home and were no longer invested in getting better.

Responses to how well the individual or unit was implementing the six functional areas of COSC were divided between 'not applying to me' and 'doing it well'. Only one third of the officers made comments relating to training or preparation for the deployment. All respondents indicated they were not adequately trained to perform this

mission. “ I was told by a superior, ‘don’t worry about it; you’ll get training when you arrive.’ I didn’t.” Another commented, “This is not the place to train us – we should be trained well before deployment.” Several officers felt command and control issues for BH units needed improvement. Other comments included; improve mental health capability in the CSH (felt it lead to higher evacuation rates), behavioral health professionals inappropriately utilized in the preventions role, doctrine or the application of doctrine needs to be more flexible for the theater.

Confidentiality issues are handled either through minimal record keeping, locking records up at the unit, or providing limited feed back to the Soldiers’ commander

Only a few respondents indicated they had worked with civilians, either contractors or Iraq nationals. Approximately one third of all interviewees did not feel adequately prepared to work with foreign nationals.

Additional comments made by the behavioral health officers included: “We need crew served weapons to meet the convoy requirements.” “The convoy requirements restrict our ability to get out and perform the mission.” There were two providers who indicated shortages or limited access to medication made it more difficult to perform the mission.

Enlisted Behavioral Health Specialists (91X) in Kuwait

Four male junior enlisted and NCOs 91X ‘s were interviewed in the CFLCC theater of operations. Interviews were conducted with two separate units at two separate locations. Both NCOs had prior deployment experience. Length of time deployed ranged from six months to nine months.

The group listed ‘lack of vehicles’ and manpower shortages (one group was short 8 personnel) as key resource problems. Communications and limited medications were also noted.

Home front problems and problems with unit leadership, were listed by all respondents as the most frequently relayed issues for Soldiers.

Only one Soldier indicated his unit did prevention activities, psycho-education classes. One Soldier whose organization did not do prevention commented, “We only do mental health.” Only one Soldier responded that his units prevention program did something that was perceived to be negative. “Anger management didn’t work. The same Soldiers kept coming back.”

The 91Xs stated the most positive clinical activities as one to one interventions and ‘running an out patient clinic or walk in clinic. “Soldiers tell their peers and they come in to see us.” One Soldier indicated as an effective clinic function his units’ ‘Smoking Cessation Program’ (arguably a prevention program). The least effective

clinical function was only identified by one Soldier, “Staffing cases with credentialed providers.”

Two individuals from the same unit indicated their unit had SOPs and had changed them as a result of the unit locating in a fixed facility. Only one Soldier had been involved in performing a Critical Event Debriefing.

Charting for all Soldiers was done on paper. All indicated that the write up went with the Soldier. The unit would only keep a copy if the Soldier was going to be evacuated.

Three respondents indicated their unit did suicide prevention classes with one Soldier commenting that his unit had Soldiers screened with the “Beck Depression Scale”. One Soldier stated his unit did nothing. Management of dangerous patients was done with line of sight (3 respondents), unit watch and removing weapons (one respondent). Only one Soldier indicated his unit was involved in monitoring clinical outcomes. One Soldier responded with, “No follow up has ever been done.”

All Soldiers responded to the questions of implementation of COCS and guidelines for COSC as not applying to their unit or mission. For suggestions on how to improve COSC, Soldiers replied more training was needed. “We don’t spend anytime on our week end drill doing COSC.” This was a similar complaint from both reserve and active units in Iraq. Several complained that when in garrison or on week end drill the only thing they do is ‘motor stables’.

Confidentiality was ensured by keeping separate from medical records, maintaining records in a locked area, and by providing a private location for interviews. No one reported having interactions with civilians or foreign nationals. There were no additional comments made.

Behavioral Health Officers in Kuwait

There were six officers interviewed in CFLCC, four male and two female. The officers represented a full range of behavior health specialties. Two officers had previous deployment experience. One officer had only been deployed for 2 months; the rest had been deployed for at least six months.

Resource shortages varied among officers. Two responded with vehicles and medications (initially) as a problem. One officer was new and unfamiliar to military psychiatry implying that his lack of knowledge created a resource problem. One officer indicated that dispersal of manpower resources created a shortage of services in some areas.

Three fourths of the officers reported home-front issues as the leading complaint from Soldiers. Leadership, boredom/no sense of purpose, and return home dates were

identified by one third of the officers interviewed. Other issues included low emotional preparation, symptom complaints, and suicidal thinking.

Half the officers stated their most effective prevention activity is doing psycho-education classes. Other interventions included giving out GTA cards on prevention subjects and doing the Beck Depression Screening test for Soldiers coming into sick call. Least effective measures included 'being stuck in the medical model', and sending Soldiers to the rear from Iraq (to Kuwait). 'They only want to hang out at the pool and lift weights'.

Effective clinical measures did not elicit multiple responses. Providers felt having a clinic, holding one to one therapy, and the ability to hold patients for seven days were the most effective interventions. Least effective included attempts to 'reintegrate Soldiers into their unit, and communication with other mental health providers.

Two thirds of the providers did not mention the use of SOPs for their organization. One responded the SOP s had been changed to reflect emergency procedures. Providers also indicated limited use and/or acceptance of Critical Event Debriefings.

All providers stated their documentation was done on paper. A copy went to the Soldier and some providers maintained a copy at the unit they were at. One organization developed their own database to keep track of workload and patient events.

Half the providers used psycho-education classes for suicide intervention. PRN hospitalization was also seen as an effective intervention. Management of dangerous patients was also handled by admitting for over half of the respondents. One third had used unit watch as a means of intervention.

All of the providers indicated the measurement of clinical outcomes for their unit was either 'very difficult' or was not being done. "A problem…Get nothing back from those who are referred on. Even the [redacted] doesn't notify us. For RTDs, no news is good news."

All providers indicated they had not implemented COSC functions into their AO. Over half felt the COSC doctrine was not appropriate for their AO. "We're too far back, and too late." Suggestions for improvement ranged from increased formal training to conferences or panel discussion at the BH Science short course.

The majority of respondents used 'consent forms' and securing files as means of maintaining confidentiality. One third of the officers had some exposure to Iraqi citizens as part of their clinical work experience. All felt that training and preparation were inadequate for the task.

Additional comments included the need for communication between CFLCC and CJTF-7 mental health professionals to coordinate treatment activities. One provider also indicated that they needed better training in fragmented orders (FRGs).

APPENDIX 5 (Summary of Line Leaders Interviews) to ANNEX B to OIF MHAT REPORT

INTRODUCTION

One-on-one interviews with battalion and brigade commanders in CJTF-7 (Iraq) and CFLCC (Kuwait) were conducted. The commanders were from both combat and combat support/combat service support units. The selection of commanders was based on whether companies in their units were identified to complete the Soldier health and well-being survey.

KEY THEMES

1. Morale is low, but improving.

Commanders and Senior NCOs reported morale was low, but that it was improving as MWR improved. R&R and mid-tour leave was identified as positively affecting morale.

2. The behavioral out-reach effort needed to be improved.

All the commanders and sergeants indicated that there was enough mental health services available and that they were generally happy with the support that they received. However, the time and resources it took to take a Soldier to see a mental health care provider was excessive.

3. In-theatre behavioral health training is possible.

There was an expressed desire to have all mandatory re-deployment training conducted in theatre, as opposed to conducting the training at home station. The sergeants believed that in-theatre training was possible as long as it was adequately planned and coordinated.

APPROACH

Procedures.

All interviews were conducted by a member of the MHAT team. Interviews began with an introduction and a description of the purpose and objective of the interview. Confidentiality and anonymity were assured. Thus, no names of any of the interviewee's were recorded. All interviews lasted approximately 60 minutes. Forty-one interviews were conducted at fourteen different locations throughout the Kuwait and Iraq area of operations with the following group composition:

Battalion/Brigade Commanders	8	Combat Arms

CSM/1SG 4 Combat Arms

Themes/Questions.

Prior to all interviews, key themes and specific questions were identified for the MHAT interviewer to address. All individuals were asked the same general questions. Below are the specific themes and questions for all interviews.

Themes/Questions: How are Soldiers doing? What people or programs are available to assist you in decreasing the stressors your Soldiers face? How do you refer your Soldiers to receive mental health? How feasible is it to conduct training in your area of operations? What resources do you have available for Soldiers that need a break (for example, sending Soldiers to the rear for R&R)?

RESULTS

Battalion/Brigade Commanders of Combat Units

A total of 8 interviews were conducted with battalion (n = 7) and brigade (n = 1) commanders from combat units. Overall, the commanders believed that low morale was an issue, but they felt it was improving as quality of life was improving. All the commanders reported that the uncertain redeployment date was a huge stressor on Soldiers and families, with the re-deployment date changing numerous times. One commander noted that the FRGs were effective in dispelling rumors about the return date. Other stressors reported by commanders included the combat environment they were in, which occurs on a daily basis; changes in officer leadership due to attendance at military schools; and brigade polices that “don’t make any sense.” One battalion commander noted that many Soldiers believe that the brigade commander doesn’t care about them. Regarding mental health assets, all the commanders stated that there were enough mental health personnel, and overall, their relationship with mental health was good. However, many commanders believed that mental health personnel needed to do a better job of coming out to the units. Several commanders noted that they lose at least two Soldiers every time they send one to mental health because of required escort, as well as Soldiers required to conduct the convoy. Commanders wanted as many mandatory re-deployment classes conducted in country rather than waiting to conduct them in garrison. The commanders also mentioned the R&R and the mid-tour leave programs. The commanders all felt these were good programs, but expressed concern that only about 40% of their Soldiers would be able to participate in at least one of them, with the other 60% not being able to go on R&R or take mid-tour leave.

Sergeants First Class/First Sergeants of Combat Units

Two Sergeants First Class and two First Sergeants were interviewed from combat units. All these sergeants reported that their Soldiers were tired and that morale was low. All four sergeants reported poor phone and mail service. There was general anger over not being able to communicate with families back home. In general, these sergeants reported that MWR was improving, but it still had a ways to go. Overall, these sergeants felt that there were sufficient mental health services available, but that the time it took to take a Soldier to see mental health was excessive. Three of the four sergeants stated that there needed to be a better outreach program. One sergeant noted that when the mental health officer did visit the base camp that he was only able to see one-third of the Soldiers who wanted help because of the limited time available. Another sergeant noted that they rely on the chaplain for mental health services. The key Soldier stressors identified by these sergeants included: family problems, financial issues, and uncertain re-deployment date. Two of these sergeants were also concerned about how Soldiers would respond during the holiday season and not being with their families. All of these sergeants believed that in-theatre mental health training was possible as long as it was appropriately planned and coordinated. All the sergeants reported that their units participated in R&R and mid-tour leave.

APPENDIX 6 (Summary of Behavioral Health Unit Data Calls) to ANNEX B to OIF MHAT REPORT

INTRODUCTION

As part of the Mental Health Advisory Team's (MHAT) mission to evaluate the behavioral healthcare (BH) being rendered in theater, the MHAT devised a data call matrix in order to gather data from the various BH units throughout theater. These units included combat stress detachments/companies, division mental health sections, and combat support hospital psychiatric sections. The data from these various units were compared and contrasted.

FINDINGS

1. Behavioral health assets had high RTD rates.

All behavioral health assets in CJTF-7, CSH, CSC, and DMHS, experienced high RTD rates ranging from 73% to 100%.

2. Reported early shortages of psychotropic medications resolved.

Thirteen of seventeen (76%) behavioral health units or slices of units report psychiatric medications are not currently a problem. Only three of the reporting units indicated they had brought medication with them to the theater at the start of the war. Thirteen of the units reporting indicate that they have regularly used medication as part of their treatment regime while deployed.

3. A universally accepted tracking system for relevant behavioral health data does not exist.

Half of the behavioral health units or slice elements report the need to develop their own "home grown" data collection system to keep track of workload and medically relevant data. Only three of the seventeen units reporting indicated they track suicide information.

METHODS AND PROCEDURES

Study Sample.

All major behavioral health units in theater were queried via telephone, email, and/or in-person between 29 August and 2 October 2003. Although some smaller,

forward-located prevention teams were not canvassed, all parent organizations and major slices were contacted. Units contacted are listed in Table 1 below.

Table 1: Units Participating in MHAT Data Call

Unit	Type of Unit	Location
[redacted]	Combat Support Hospital	[redacted]
[redacted]	CSC Unit	[redacted]
[redacted]	CSC Unit	[redacted]
[redacted]	Psychiatric Section, ASMB	[redacted]
[redacted]	Combat Support Hospital	[redacted]
[redacted]	CSC Unit	[redacted]
[redacted]	Combat Support Hospital	[redacted]
[redacted]	Division Mental Health Section	[redacted]
[redacted]	Combat Support Hospital	[redacted]
[redacted]	CSC Unit	[redacted]
[redacted]	CSC Unit	[redacted]
[redacted]	Combat Support Hospital	[redacted]
[redacted]	Division Mental Health Section	[redacted]
[redacted]	CSC Unit	[redacted]
[redacted]	CSC Unit	[redacted]
[redacted]	Division Mental Health Section	[redacted]
[redacted]	Combat Support Hospital	[redacted]

Procedures.

The MHAT traveled throughout the Kuwait (CFLCC) and Iraq (CJTF-7) operational theaters interviewing and surveying BH personnel. In addition, the MHAT gathered utilization, medication, documentation, and other unit data. Data was gathered via telephone, email, and in-person during MHAT visits to the units.

Data was collected in matrix form. The MHAT then tabulated, compared and contrasted the data.

Survey Instrument.

The matrix was constructed by the MHAT members following their deployment to theater. No standardized questions, matrices or frameworks were utilized, though most of the questions were devised by consensus of the team members. The questions range on a variety of topics of interest to the MHAT mission, such as utilization, handling of mental health patients, documentation methods, reporting methods, medication availability, suicide tracking, etc. A list of the questions can be found at Tab A.

TAB A: Data Matrix Questions

Unit
Type of Unit
Location

- What is the unit's BH holding capacity?
- What is the unit's BH return to duty (RTD) rate?
- What is the unit's BH evacuation rate?
- How many BH providers are present in the unit?
- How many BH providers are authorized on the unit MTOE?
- How many Soldiers does your unit support?
- Do you have a locally developed database to track your patients/activities?
- When a patient is evacuated, with whom do you send the clinical/admin paperwork?
- When a patient is evacuated, does the unit keep a copy of the clinical/admin paperwork?
- How many (if any) of those who completed suicide in your unit's area of operation were receiving BH treatment?
- How many (if any) of those who attempted suicide in your unit's area of operation were receiving BH treatment?
- How many suicidal patients has your unit treated?
- Does you unit have a suicide tracking system?
- Does you unit use COSC-WARS to track activities?
- Are psychotropic medications available in your unit?
- Did your unit bring psychotropic medications with you into theater?
- Did your unit need psychotropic medication at all?
- What psychotropic medications do your unit need?
- Does your unit have a formulary?
- Is the unit's current psychological testing kit adequate?
- Did your unit have adequate laboratory support?

APPENDIX 7 (Summary of Fort Stewart Data) to ANNEX B to OIF MHAT REPORT

PURPOSE

The MHAT visited Fort Stewart to review the impact of the 3rd ID deployment to OIF deployment on the behavioral healthcare system.

METHODOLOGY

Interviews with key informants, review of behavioral health clinical files, review of patient administration databases.

FINDINGS

1. Soldiers returning from OIF for behavioral health problems had good access to follow-up care.

Details of home station disposition of Soldiers who returned to Ft. Stewart for behavioral health reasons are reviewed in the Evacuation Annex. To summarize, of the number (49) of Soldiers who returned to Ft. Stewart from deployment to Iraq or Kuwait for behavioral health reasons, 84% (41) followed up with behavioral health services upon their return. The median number of visits to behavioral health was four. Out of the group of behavioral health returnees, only three returned as psychiatric inpatients. The Ft. Stewart MEDDAC was well prepared to receive and follow Soldiers who returned for behavioral health problems, or who sought behavioral health services upon their return to Ft. Stewart. The majority (83%) of the returnees were seen within one week of their return, although the clinic had capacity to provide unlimited daily walk-in evaluations in addition to scheduled appointments.

2. U.S. Army Reserve and National Guard Soldiers became a significant new beneficiary population for behavioral health services at Ft. Stewart. This caused a sustained reduction in family member behavioral health services.

Ft. Stewart is a power projection platform and in essence has become the home station for thousands of mobilizing and demobilizing Reserve Component (RC) Soldiers. RC Soldiers who utilized behavioral health services while at Ft. Stewart became a new beneficiary group for the MEDDAC and competed with availability of BH services for family members. Normally, the majority of patients seen at the MEDDAC for behavioral health services are non-active beneficiaries since the 3ID Division Mental Health Section provides care for most of the Ft. Stewart active duty Soldiers. As 3ID Mental Health prepared to Kuwait, the MEDDAC Behavioral Health Department assumed responsibility for active duty behavioral health care. Services were curtailed for non-active duty beneficiaries but anticipated to resume once 3ID deployed. The demand for behavioral health services by active duty personnel did not abate as expected but continued to grow progressively. The proportion of active duty contacts in the

Behavioral Health Clinic was 23% during October 2002, but grew steadily by month to achieve a high of 92% in August 2003 primarily due to activated RC personnel. The number dropped in September to 80% and may continue to drop as the 3ID Mental Health Section resumes clinical operations. The number of non-active duty appointments was reduced, and child services were sharply curtailed. Contracts for additional providers had been approved and new hiring actions had been initiated.

3. The redeployment of 3ID was associated with a spike in psychiatric inpatient admissions approximately 30 days after redeployment.

The average monthly census for inpatient psychiatry from September 2002 to August 2003 was four patients per day. In September 2003 the average daily census climbed to eight patients per day. Between 3 Aug - 13 Oct 03, 33 Soldiers who had deployed to OIF had been admitted for inpatient psychiatric treatment. Of these 33 patients, 70% (23) were considered by the staff to be admitted for reasons that were directly related to their OIF deployment, primarily depression, post-traumatic stress, and adjustment problems.

4. Aggressive behavioral health screening was conducted with redeploying OIF Soldiers. Nearly 500 Soldiers were connected with follow-up assistance based on this screening initiative.

Approximately 13,000-14,000 Soldiers redeploying to Ft. Stewart were screened with a questionnaire that identified behavioral health concerns. A behavioral health provider reviewed the completed questionnaire with each Soldier, and where indicated, made a formal or informal referral to a behavioral health or community agency. A sample 1,339 completed screening forms were reviewed to determine screening outcomes. Of those screened, 6% (approximately 840) were referred for follow-up assistance. Of those referred, 58% (approximately 487) followed up with the agency to which they were referred. These results indicate that nearly 500 Soldiers were offered and accepted assistance reported behavioral health concerns identified from screening.

5. The current division surgeon and two Bde surgeons support the concept of assigning BH teams to each BCT.

The 3rd is currently undergoing reorganization from three BCTs to five BCTs. The Division Surgeon and both of the BCT surgeons interviewed support the concept of having BH teams assigned to each of the BCTs. The current number of BH officers assigned to the division is not enough to support the current 3-Bde configuration. Additional BH officers will be needed to support the new 5-Bde configuration. The division surgeon has submitted an unmet requirement for 3 additional social work (73A) or psychology (73B) officers.

In addition, the two interviewed Bde surgeons and the 5 interviewed BN PAs stated that the minimum rank for the mental health specialists (91Xs) should be Sergeant (E5) due to the needed skill level and maturity to perform their mission.

6. The two Bde surgeons and the five Bn PAs from the 3rd ID recommend giving battalion aid stations a basic load of psychotropic medications.

All of the primary care providers interviewed at the 3rd ID (2 Bde surgeons and 5 Bn PAs) reported that they needed psychotropic medications – particularly SSRIs, non-SSRI antidepressants, and sleeps aids – at the battalion aid stations during OIF. They recommend that these medications be part of their basic load of medications for all deployments.

APPENDIX 8 (Distribution of BH Services) to ANNEX B to OIF MHAT REPORT

INTRODUCTION

As part of the OIF Mental Health Advisory Team's (MHAT) mission to evaluate the behavioral healthcare (BH) being rendered in the OIF theater, the MHAT examined BH staffing and distribution. In particular: Are there enough BH personnel in theater to successfully accomplish the BH mission? Are the BH personnel/units adequately distributed throughout theater in order to successfully execute the BH service mission?

In order to answer these questions the MHAT generated a layout of the BH resources in theater (as of mid-Sep 03) and examined a number of possible methods for estimating the need for and positioning of BH personnel. Finally, the MHAT considered various evaluation strategies for each estimation method. The details of this analysis are in the discussion following the findings and recommendations generated by the analysis.

Due to the constant changing battlefield and the concomitant shifts in personnel, the validity of parts of this analysis is very time limited. The data gathered for this analysis took place between 27 August and 2 October 2003. For convenience, mid-September 2003 will be used as the target date. Changes made following mid-September are not reflected in this analysis. Further, data on several variables were sketchy and often unverifiable. Findings and recommendations may be influenced by these considerations and should thus be judged in this light.

FINDINGS

1. Although the number of BH personnel in theater was sufficient to provide coverage throughout the OIF Area of Responsibility (AOR), there were areas in theater that lacked BH services.

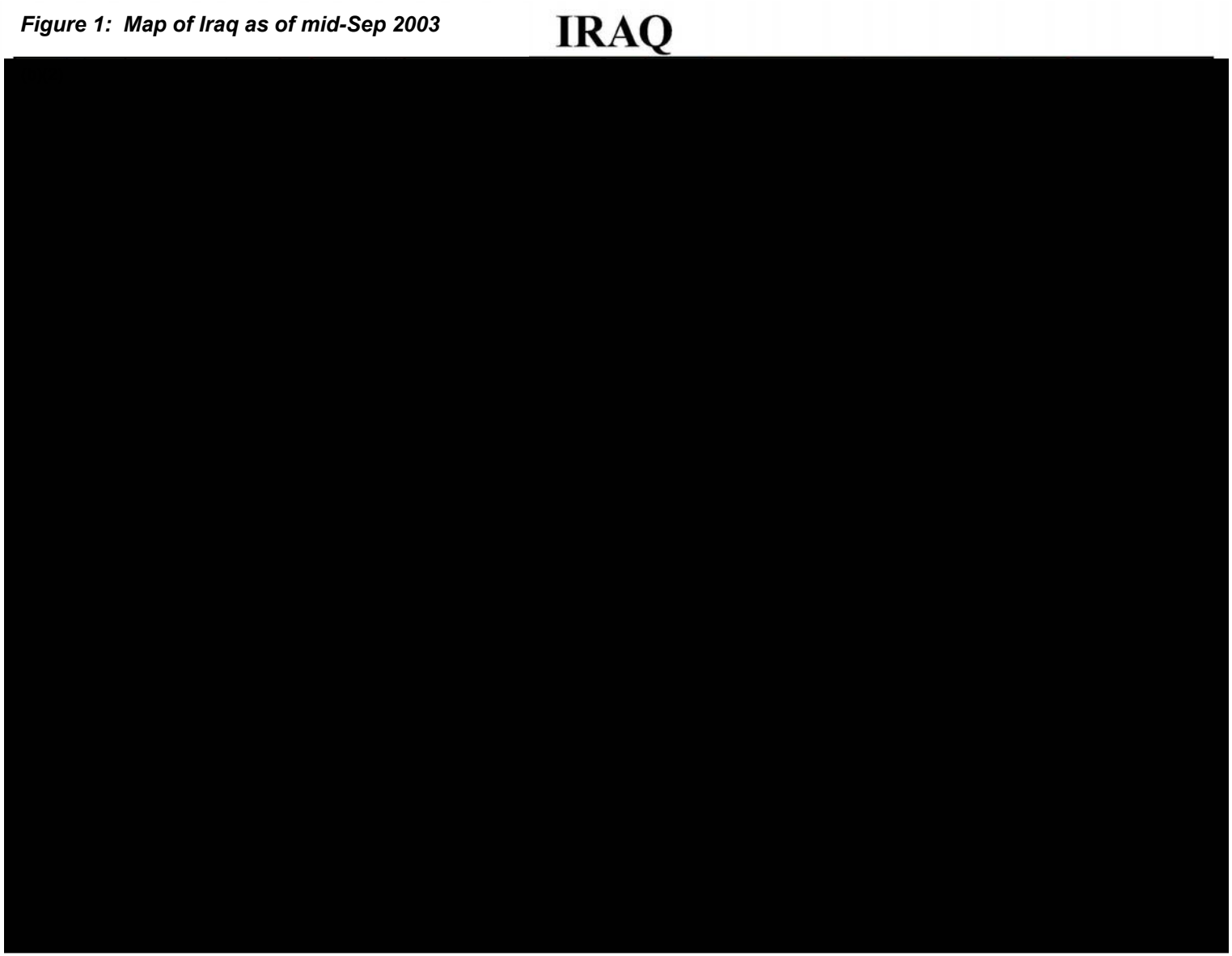
While conventional metrics for assessing sufficiency show that BH clinical services are meeting Army operational expectations, however, Soldiers report significant unmet behavioral healthcare needs (see Annex A). Some areas had very few or no BH services ([redacted] Iraq, [redacted] Kuwait, and in the [redacted]), and few of the smaller forward operating bases received regular BH outreach services.

Table 2 lists the numbers of BH personnel in each of the respective areas (Kuwait and [redacted] Iraq). This shows that there are several zones with little or no BH support (see Figure 1). The numbers of Soldiers in Table 2 have been rounded to the nearest 1000 for security purposes, however, there are very likely greater numbers of Soldiers in each area than listed since truck drivers and other support personnel actually living in one region may be assigned to a unit that is based in another region. Further, special operators were not listed in the numbers provided to MHAT.

Table 2: Regional BH Personnel to Soldier Ratios
(Number of Soldiers rounded to nearest 1000 for OpSec)

UNIT	BH	SOLDIERS	RATIO
[redacted]			
GRAND TOTAL	**163**	138000	**846**

Figure 1: Map of Iraq as of mid-Sep 2003



2. BH assets were fielded doctrinally under-strength and therefore in an "economy of force" mode.

Although the divisions deployed with their organic BH assets, the 4th ID deployed without its social work officer (33% of their professional staffing). The CSHs conducted split-based operations, which reduced their ability to effectively provide BH services. The [redacted] had an operational BH section, but the [redacted] only had a single psych nurse assigned who was chief of an intermediate care ward. The [redacted] [redacted] had a single psychiatrist and a single 91X who was not being used in her MOS. The [redacted] had no BH assets and utilized part of the [redacted] and a fitness team from the [redacted] in that role.

According to FM 8-55, the basis of allocation for CSC detachments is 1 per division or 1 per 2-3 separate brigades. CSC companies are allocated 0.5 per division (see Table 1). Table 2 below lists the basis of allocation for fitness and prevention teams, the actual number on hand, and differences. Based on this analysis, CSC units are short 3 fitness teams and 2 prevention teams. However, when calculated based on maneuver unit requirements, there are sufficient fitness teams, but a shortage of 4 prevention teams. This seems to support what the MHAT noted in theater: there were sufficient restoration resources, but a lack of outreach services.

Table 1: CSC Unit Base TOE (Fitness and Prevention Teams)

Unit		**Basis of Allocation**		**On-Hand**		**Missing**	
Unit	TOE	Fit	Prev	Fit	Prev	Fit	Prev
[redacted] CSC Det	MF2K	1	3	0	3	-1	0
[redacted] CSC Det	MRI	2	4	1	3	-1	-1
[redacted] CSC Det	MF2K	1	3	1	3	0	0
[redacted] CSC Co		4	6	3	5	-1	-1
TOTAL		**8**	**16**	**5**	**14**	**-3**	**-2**

Table 2: Doctrinal Distribution for CSC Teams (Fitness and Prevention Teams)

AORs		**Basis of Allocation**		**On-Hand**		**Missing**	
Unit	BCTs	Fit	Prev	Fit	Prev	Fit	Prev
101st ABN Div	3	1	3	1	3	0	0
4th ID*	4	1.5	4.5	2	4	0.5	-0.5
3rd ACR	1	0.5	1.5	0	2	-0.5	0.5
1st AD**	5	2	6	2	5	0	-1
5th Corps***	N/A	4	6	N/A	N/A	N/A	N/A
TOTAL	**13**	**9**	**21**	**5**	**14**	**-4**	**-7**

- *Includes [redacted] .*
- *** Includes [redacted] .*

*** The Corps is allocated one CSC company to cover non-divisional units.*

Outreach and far-forward stationing will be critical in some units if Soldiers are to receive BH services. Mental health or CSC teams were located at most of the maneuver brigade/ACR medical companies, but only because they were augmented with external BH assets. The [redacted] and the [redacted] both controlled sizeable tracts of land

and troops, but have no organic BH personnel. Although they were to be augmented by a single prevention team each, two were needed to cover the [redacted] that was responsible to cover the vast western region; more were probably needed. In the [redacted], there was only one prevention team from the [redacted] that visited occasionally. They had no CSH, or DMHS support within a two-hour drive. The [redacted] did receive local outpatient and brief inpatient support from a USAF social worker at the small ASAF medical treatment facility at the airfield.

Table 3 lists all of the units in OIF that had BH personnel organic to them. Outside of the CSC and DMHS units, BH personnel were scattered in amongst the medical personnel – perhaps without much central direction or support as noted in the BH Survey findings (see Appendix 1).

Table 3: BH Units in OIF in mid-September 2003

UNIT	LOCATION	COMMENTS
Medical Brigade Psych Staff		
[redacted] Med Bde	[redacted] Kuwait	Medical C2 for CFLCC AOR
[redacted] Med Bde	[redacted] Iraq	Medical C2 for CJTF-7 AOR
Combat Stress Control Units		
[redacted] Med Det	[redacted] Iraq	
[redacted] Med Det (MRI)	[redacted]	Short 1 Fitness Team and 1 Prev Team
[redacted] Med Det (MF2k)	[redacted] Iraq	Short 1 Fitness Team
[redacted] Med Co	[redacted] Iraq	Short 1 Fitness Team and 1 Prev Team
Combat Support Hospital Psychiatric Sections		
[redacted] CSH (North)	[redacted] Iraq	No BH assets (used 98th CSC)
[redacted] CSH (South)	[redacted] Iraq	Only 1 (psychiatrist) working in BH
[redacted] CSH (North)	[redacted] Iraq	1 Psych Nurse (working Med-Surg)
[redacted] CSH (South)	[redacted] Iraq	Inpt ward, but only stabilization services
[redacted] CSH	[redacted] Kuwait	Local outpt; Inpt only for evacuation
[redacted] CSH	[redacted] Kuwait	Minimal local outpatient through clinics
Division MH Sections		
[redacted] AD DMHS	[redacted] Iraq	
[redacted] ID DMHS	[redacted] Iraq	Short its social work officer
[redacted] ABN DMHS	[redacted] Iraq	
Area Support Medical Battalion Psych Sections		
[redacted] ASMB	[redacted] Kuwait	One social worker
[redacted] ASMB	[redacted] Iraq	One psychiatric PA

as of 15 Sep 03

3. There is sufficient CSC holding capacity except in Kuwait.

Each fitness team (3 officers + 7 enlisted) can care for approximately 25 ambulatory, non-psychotic, Soldiers. The MHAT noted that the daily average census at the restoration units was between 2-5, some reported surges reaching 9-12. However, Kuwait (and [redacted] Iraq) had no restoration or reconditioning functions. For the most part,

BH units in Kuwait chose to perform outpatient therapy with local Soldiers and to continue to evacuate to the rear those Soldiers evacuated from Iraq (as noted by the low 11% RTD in Kuwait).

The [redacted] that arrived in CFLCC about 10 March was attached to CJTF-7 during the ground offensive, deployed into Iraq in early April, and was redeployed to CONUS and inactivated in June 03. CFLCC has had only the holding capacity of a clinic staffed by the [redacted] and what could be provided at the [redacted]. Table 4 lists the BH holding capacity in Kuwait.

Table 4: BH Holding Capacity in Kuwait

UNIT	LOCATIONS	PSYCHIATRIC STAFF
Northern Camps	North Kuwait	None
[redacted] CSH	[redacted]	8-12 beds
[redacted] CSH	[redacted]	None
[redacted] Clinic	[redacted]	Minimal overnight holding
[redacted] Clinic	[redacted]	[redacted] ASMB - minimal overnight holding

4. All CSC restoration capacity was in the Divisions' rear areas and near CSH assets.

The MHAT noted that all five CSC fitness teams were located in the divisional support areas and often located close to a CSH (see Table 1). Collocating the CSC fitness teams with the CSHs was implemented in various ways, but was not done on the basis of a proper mission analysis. The [redacted] CSC became the BH clinic within the [redacted]t CSH with whom they were collocated. The [redacted] and the [redacted] CSC fitness teams purposely positioned themselves away from the CSHs (though on the same camp) in order to maintain their autonomy and to "de-pathologize" the restoration process.

Table 1: CSC Fitness Team Locations

DIVISION AREA OF RESPONSIBILITY	LOCATION	PARENT UNIT	NEARBY CSH
101st ABN Div Support Area	[redacted]	[redacted] CSC Co	[redacted] CSH [redacted]
4TH ID Support Area	[redacted]	[redacted] CSC	[redacted] CSH [redacted]
4th ID [redacted] Support Area	[redacted]	[redacted] CSC Co	[redacted] CSH [redacted]
1st AD near Division HQ and AVN Bde	[redacted]	[redacted] CSC Det	
1st AD AOR	[redacted]	[redacted] CSC Co	[redacted] CSH [redacted]

5. Time-distance under tactical conditions present significant barriers to care.

The MHAT observed that convoy procedures (requirements for two or more persons per vehicle, three vehicles in a convoy, front and rear vehicles equipped with functioning radios, and at least one crew-served weapon in the convoy – manned by a non-medical MOS Soldier) present a significant barrier to mobility. Further, many of the brigade

combat teams and battalions had dispersed their subordinate units over wide tracts of land in small forward operating bases (FOBs). This dispersion added to difficult mobility made outreach very difficult throughout the CJTF-7 AOR. Kuwait also had mobility problems. In order to leave certain camps in Kuwait, one was required to either have a colonel (O6) in the vehicle or have a specific memo from a colonel (O6) each time one left the camp.

Alternative means of consultation were also difficult because of telecommunication shortages and poor reliability. Conversely, line units have the same or larger costs to bring overstressed Soldiers to the BH teams' base areas or to communicate with BH personnel.

RECOMMENDATIONS

1. Appoint a Theater/Area of Operation BH consultant to advise the Surgeon on BH issues.

In order to better allocate BH personnel and to oversee the delivery of BH care in the AOR, the commander should appoint a BH consultant to each theater/AOR surgeon. This officer may be already on staff, or could be requested through personnel channels if a suitable choice is not available. Important aspects of this positions should include conducting a theater/AOR-wide BH needs assessment and recommending to the commander(s) a proper distribution of BH units/teams on the battlefield.

2. AOR BH consultant need to distribute BH to sufficiently cover service gaps.

The MHAT noted gaps in BH services in theater. In particular, BH personnel were not optimally distributed. In order to remediate this, theater BH consultants need to review their respective AORs to ensure that BH personnel are optimally distributed and that the services rendered provide a consistent network of BH services. Where gaps are noted, BH units need to be redirected to provide the needed service. Because of the dispersion-mobility problems, it may enhance outreach to forward locate small teams at more of the FOBs and then have them coordinate to cover one or two other nearby FOBs. The more BH personnel are forward located, the less the mobility problem will influence the mission.

3. Utilize fitness team personnel to provide local outreach.

Fitness team officers of all specialties and the mental health and occupational therapy enlisted should provide aggressive outreach and preventive education to units in the same camp when their restoration duties allow. Fitness team personnel can also be reconfigured into prevention teams or augment existing prevention teams.

APPENDIX 9 (Psychotropic Medication Issues) to ANNEX B to OIF MHAT REPORT

INTRODUCTION

The MHAT sought to clarify questions related to the availability of psychotropic medications in OIF. In particular:

1. Is there a shortage or unavailability of psychotropic medications?
2. What psychotropic medications should be available on the formulary?
3. Is laboratory support sufficient to support psychiatric evaluations and treatment?
4. How have psychotropic medication shortages (if any) been managed by behavioral health units?

FINDINGS

DATA Finding #1: Forward deployed behavioral health units report greater dissatisfaction with the availability of psychotropic medications, than units located in the rear.

Dissatisfaction with the availability of psychotropic medication was particularly high among Combat Stress Control units and Division Mental Health Sections (57.1 & 66.7% respectively). Unlike units at higher levels of care, these units do not have an integrated pharmacy to immediately dispense medication. Anecdotal reports from forward-deployed psychiatrists indicate that filling prescriptions is unnecessarily complicated by forcing Soldiers and units to arrange at least two convoys – one for the Soldier's medication evaluation and prescription, and another for the medication pick-up at the nearest pharmacy.

Despite these concerns, forward deployed psychiatrists were not able to provide concrete evidence that their patients were less compliant with medications, had failed to fill prescriptions, were prematurely evacuated, or had suffered a bad medical outcome due to difficulty in acquiring psychotropic medications.

For units at higher levels of care, particularly those with direct pharmacy support, the dissatisfaction with the availability of psychotropic medication was lower. Even so, 50% psychiatrists and nurses at Combat Support Hospitals still reported dissatisfaction with psychotropic medication availability.

Anecdotal reports indicated that psychotropic medications were in short supply during the initial phase of the conflict; that the range of available medications was limited to a few selections; and that there was no process to make formulary recommendations to the pharmacy before the deployment occurred.

DATA Finding #2: **Behavioral health units need a broader range of antidepressant and sleeping medications. The addition of stimulants to the formulary is requested.**

Fifty percent (50%) of the surveyed psychiatrists identified a need for a broader range of antidepressant medications in the current formularies, and 33% indicated that additional sleeping agents and stimulants would be helpful for treating patients.

DATA Finding #3: **To overcome anticipated psychotropic medication shortages, some DMHS and CSC units deployed with unregulated medications.**

Although the intent was to enhance patient care, 25% of forward deployed behavioral health units dispensed psychotropic medications from unregulated medication stockpiles. How these stockpiles were initially obtained is unclear. There did not appear to be adequate medication formularies or dispensing records.

Poor visibility in this matter creates an unnecessary liability for the provider and theater medical command. It is unclear which medications are available, how many are stockpiled, where they are being stored, and to whom they are being dispensed. Side effects and adverse medication outcomes cannot be adequately tracked.

RECOMMENDATIONS

Immediate implementation:

(1) Ensure availability of psychotropic medications as far forward as possible – CSC providers are rarely located close to pharmacy services, and travel between locations in theater is both time consuming and dangerous. In order to facilitate proper and timely care, theater medical commanders should either authorize psychiatrists and psychiatric nurse practitioners in CSC/DMHS units to possess and disburse medication or stock forward support battalions or battalion aid stations located closest to BH medical prescribers with adequate psychotropic medications to support these providers. If BH providers are authorized to possess and disburse psychotropic medications from their units, proper procedures should be implemented to regulate this process.

(2) Ensure BH Input into Formulary Recommendations – The BH consultants to the CFLCC and CJTF-7 Surgeons should encourage development of processes by which psychiatrists, psychiatric PAs and nurse practitioners in far forward units (DMHS, CSC, and ASMBs) can request additions and changes to the formularies of supporting pharmacies.

(3) Broaden Current Formularies – Broaden the current pharmacy formularies to include SSRIs, non-SSRIs, and several sleeping medications. At a minimum, the formulary should include these additional medications:

Table 1: Recommended Additions To CSH Formularies

SSRI	Non-SSRI	Sleeping Agent
Fluoxetine (Prozac)	**Venlafaxine** (Effexor)	***Trazodone*** (Desyrel)
Paroxetine (Paxil)	**Bupropion** (Wellbutrin)	***Zolpidem Tartrate*** (Ambien)
Sertraline (Zoloft)		***Clonazepam*** (Klonopin)
Citalopram Hydrobromide (Celexa) Or ***Escitalopram Oxalate*** (Lexapro)		

Future implementation:

Convene a Process Action Team (PAT) to update doctrine and procedures for BH units (CSC/DMHS) to possess and disburse psychotropic medications – To improve patient accessibility to psychotropic medications in the combat environment, MEDCOM should convene a multidisciplinary PAT to consider authorizing limited pharmacy capabilities to DMHS and CSC units during deployment. The panel should consist of TOE representatives from psychiatry, nursing, pharmacy, and medical leadership. Issues to address should include extent of the formulary, resupply, medical reporting, security, and dispensing. The battalion aid station and/or dental units can be used as models.

DISCUSSION

MHAT used the Behavioral Health Survey, Behavioral Health Interview, and LRMC Chart Review information to prepare this analysis. There was no comprehensive psychotropic medication prescription or utilization tracking system in OIF.

I. Behavioral Health Surveys and Interviews

Instrument Development: MHAT developed survey and interview instruments to test the questions related to the availability of psychotropic medications, laboratory services, and kinds of medications used.

Statements and questions appeared in the Behavioral Health Provider Survey. The respondent was directed to circle a number corresponding to the degree to which he/she agreed or disagreed with the survey statement. The degree of responses ranged from *Strongly Disagree* to *Strongly Agree*. Other survey questions asked the

respondent to write in an answer. Pertinent survey statements and questions are listed below:

- There has been adequate availability of appropriate psychiatric medications. (Circle number)
- What medications have been needed, but not available? (Write in answer)
- Laboratory services have been sufficiently available. (Circle number)
- What labs have been needed but not available? (Write in answer)

The Behavioral Health Provider Interview posed these questions:

- What resources do you lack to conduct your mission? How does it impact?

Survey Method: Units selected for the survey were Division Mental Health Sections, Combat Support Hospitals, Combat Stress Control Medical Detachments and Companies, and Area Medical Support Battalions. Behavioral Health Officers, Mental Health NCOs, Mental Health Specialists, and Occupational Therapy Technicians were selected to participate in the survey. Surveys required approximately 45 minutes to complete. A non-attribution environment was provided for participants. Surveys were collected by MHAT personnel and later entered into a database for analysis. No error analysis was conducted to assess mistakes made during data entry.

Interview Method: Units selected for the survey were Division Mental Health Sections, Combat Support Hospitals, Combat Stress Control Medical Detachments and Companies, and Area Medical Support Battalions. Behavioral Health Officers, Mental Health NCOs, Mental Health Specialists, and Occupational Therapy Technicians were selected to participate in the interviews. Interviews were conducted in small groups, comprised of 3-5 personnel. Whenever possible, officers and enlisted groups were interviewed separately. Interviews were conducted by 1-2 MHAT personnel, and required approximately 1 to 1½ hours to complete. A non-attribution environment was provided for the interview participants. MHAT personnel took interview notes during the session, and later entered these notes into a database for analysis. No error analysis was conducted for to assess mistakes made during data entry.

Analysis of Surveys and Interviews: Analysis of the surveys and interview database utilized tools in Microsoft Access. For the purposes of this psychotropic medication analysis, only the responses of psychiatrists and psychiatric nurses were used. The responses of others were excluded because their unfamiliarity with medications and laboratory requirements would likely skew results. Results were compared to the raw number of database entries for the purpose of generating a ratio or percent value.

II. LRMC Chart Review

Source of Data: Using both TRAC2ES and LRMC's homegrown database, MHAT identified Army behavioral health evacuees that were transferred from OIF to LRMC. All of these behavioral health charts, both inpatient and outpatient, were requested by the MHAT for review. MHAT personnel reviewed the charts for information considered relevant to Army OIF behavioral health evacuations, and entered this information into a Microsoft Access file. For the purposes of this psychotropic medication analysis, MHAT identified number of patients evacuated using medications, and types of medications prescribed in OIF. The list of data points collected in this chart review appears in Annex D.

Method of Analysis: Analysis of the LRMC Chart Review database utilized tools in Microsoft Access and Excel. Sorting results were compared to the total number of database entries for the purpose of generating a ratio or percent value.

RESULTS

Availability of Psychotropic Medications: From 27 Aug – 30 Sep 03, 52% of the 25 psychiatrists and psychiatric nurses reported that psychotropic medications were not adequately available. Table 1 shows the results by type of behavioral health unit.

Table 1: Availability of Psychotropic Medications

Type of Unit	# of Disagree & Strongly Disagree Responses	# Of Respondents	% Disagree or Strongly Disagree
Division Mental Health Section	2	3	66.7
Combat Stress Control Co/Det	8	14	57.1
Combat Support Hospital	3	6	50.0
Medical Brigade	0	2	0.0
Total	**13**	**25**	**52**

Types of Psychotropic Medications Needed: Of those psychiatrists who reported that psychotropic medications were not adequately available, 50% indicated the need for a broader range of antidepressant medications to include several SSRIs and non-SSRIs. Thirty-three percent indicated that hypnotics/sleeping medications (such as Trazodone, Restoril, and Ambien) would be helpful in the formulary. Thirty-three percent reported that stimulants, such as Ritalin, should be available in the formulary.

Availability of Laboratory Services: Although less than half of the 25 psychiatrists and psychiatric nurses reported laboratory services were not adequately available to support psychiatric evaluations and treatment, those in hospital settings tended to be more dissatisfied with lab support (see Table 2). Providers indicated that among the needed laboratory studies were blood alcohol level, urine drug screen, thyroid stimulating hormone, and serum levels of mood stabilizers (i.e., Depakote, Tegretol, and Lithium).

Table 2: Availability of Laboratories

Type of Unit	# of Disagree & Strongly Disagree Responses	# of Respondents	% Disagree or Strongly Disagree
Division Mental Health Section	1	3	33.3
Combat Stress Control Co/Det	6	14	42.9
Combat Support Hospital	4	6	66.7
Medical Brigade	0	2	0.0
Total	11	25	44.0

Early Medication Shortages: Behavioral health units without direct pharmacy support (i.e., DMHS and CSC units) anecdotally reported that medications were difficult to prescribe during the initial phase of the conflict. Anticipating this shortage, 25% (2) of 8 behavioral health units deployed with a supply of unregulated psychotropic medication to cover expected shortages.

APPENDIX 10 (Pastoral Care Assessment) to ANNEX B to OIF MHAT REPORT

PURPOSE

The OIF MHAT Pastoral Care assessment provides an overview of the Unit Ministry Team (UMT) involvement in suicide prevention training and behavioral health care of Soldiers deployed to Kuwait and Iraq, to include care of families and Soldiers at Ft. Stewart, Georgia during and after deployment of units from that installation.

METHODOLOGY

All instruments and reports developed and utilized by the MHAT were reviewed to discover findings applicable to UMTs, to include the UMT survey and interviews conducted with various chaplains in theater and at Ft. Stewart. The UMT survey was developed at the beginning of the deployment, to collect data from both chaplains (56A) and chaplain assistants (56M) regarding suicide prevention efforts, relationships to commanders and mental health providers, and to discern what issues were most important to Soldiers and to UMTs. The UMT survey was given to 94 UMT members located throughout Kuwait and Iraq.

BACKGROUND

The Office of the Surgeon General's (OTSG) inclusion of a pastoral care consultant on the OIF MHAT is a powerful reinforcement of the relationship of Unit Ministry Teams (UMTs) with behavioral health and the importance of pastoral care to the well being of Soldiers. Chaplains and Chaplain Assistants have always been key members of the commander's team for identifying Soldiers who have needs, whatever those needs might be, and assisting the commander in meeting those needs. UMTs are significant providers of mental, behavioral, and emotional health care when they provide Religious Support to Soldiers and their families. UMTs are one portal for Soldiers to access behavioral health care and, vice versa, an important portal for behavioral health providers to access Soldiers.

FINDINGS

From the UMT Survey:

1. Many UMT personnel are not trained in the Army's suicide prevention program.

Nearly half (46%) of the UMT personnel have not been trained in the current Army suicide intervention techniques -- the Applied Suicide Intervention and Skills Training (ASIST) or in the Army's "Menningers" course for UMTs. Significantly more active

component UMT personnel have been trained in ASIST/Menningers (74%) than have reserve component UMT personnel (34%).

2. Many UMT members conducted suicide prevention training for their units prior to deploying.
69% of the respondents stated that they had conducted suicide prevention training for their units prior to deployment. Of the 31% who did not, 42% stated that they joined the unit following deployment, 19% stated that someone else had done the predeployment briefings for the unit, and 12% stated that they did not do it predeployment because they do it annually or quarterly. Only 15% said that they did not do it because they were too busy or didn't have command support. Most of the training given was given that the company (46%) or battalion (34%) level.

In addition, most (77%) UMT members felt competent in providing a quality unit suicide prevention program. Only 4% reported not feeling competent to do so. However, the enlisted members and those from the reserve components felt significantly less competent than their officer or active component counterparts.

3. Some commanders have not taken ownership of or are not resourcing their unit's suicide prevention program.
While 56% of the respondents felt the commander was taking ownership and resourcing the unit suicide prevention program, 16% felt the commander was clearly not taking ownership of the program; 28% of the respondents felt the commander was only lukewarm about the unit suicide prevention program. Enlisted UMT members and those from the reserve components feel significantly stronger that their commanders are not taking ownership and/or resourcing the suicide prevention program compared with their officer or active component counterparts.

4. Many chaplains do not feel their relationship with their local BH providers is functional.
While only 16% report a poor functioning relationship, only 55% feel they have a good one. Further, the enlisted UMT members and those from the reserve components report a significantly poorer relationship with their local BH provider(s) than their officer or active component counterparts.

5. Uncertain redeployment dates, family separation/problems, and command/leadership problems are the three main issues impacting Soldiers.

Table 1: UMT's Perception of the Top Five Issues Impacting Soldiers

Issue	Number	Percent of Respondents
Uncertain Redeployment Dates	53	56%
Family Separation or Family Problems	42	45%
Command/Leadership Relations	27	28%
High OPTEMP / Work Conditions	21	22%
Communication with Home	19	20%

6. Better logistical support, certain redeployment dates, and having units fully staffed with trained UMT members were the top three things that would best impact the UMT mission.
26% of the respondents identified logistical shortages as the single biggest issue impacting their UMT mission. UMT members identified the need for items such as computers, printers, internet access, phone access, a vehicle, tentage, and religious education/family support materials.

14% of the respondents identified having a certain redeployment date as most helpful to their UMT mission. 13% identified having their units fully staffed with personnel who are trained and spiritually committed. One division chaplain noted that he was short 7 battalion chaplains at the time of the survey.

7. UMT members identified other chaplains, family, and other Soldiers as their primary source of personal support.
38% of the UMT members reported another chaplain as a source of support, 25% identified family as a source of support, and 21% reported other Soldiers as a source of support. 13% of the UMTs identified God as a source of personal support.

From the Soldier Well-Being (SWB) Survey:

8. Soldiers report high levels of distress and interest in receiving help.
Sixteen (16%) of OIF Soldiers reported currently experiencing a moderate and 7% reported currently experiencing a severe stress, emotional, or family problem. Overall, 15% of Soldiers reported interest in receiving help. Use of mental health services. Of the Soldiers who screened positive for depression, anxiety, or traumatic stress, only 27% reported receiving help at any time during the deployment from a mental health professional, general medical doctor, or chaplain. Of the Soldiers who reported interest in receiving help, only 32% received some form of help.

From the Behavioral Health Survey:

9. BH personnel generally have good communications with the commanders and unit ministry teams (UMT) in their areas of operation.
65% of the respondents reported good communications with local commanders and 71% reported good communications with their local UMT. Only 11% and 8% (respectively) felt they had particularly poor communications. And, 82% report that commanders in their area of operations actively request BH services.

From the Primary Care Survey:

10. Primary care personnel generally refer Soldiers with BH issues to a BH provider.

80% of the respondents refer their patients with BH issues to a BH provider. 20% will refer them to a chaplain, and 10% may treat them directly. This varied by rank. Enlisted primary care personnel never treated patients with BH issues themselves, while 16% of the officers would treat them directly.

From Behavioral Health Interviews:

11. Chaplains are viewed as excluding behavioral health providers from the 'chaplain's program.'
Slightly less than half of the behavioral health officers indicated suicide prevention classes as their most effective intervention. Several indicated they did not do suicide prevention because they viewed it as a chaplain program. "We have also been instructed not to do suicide prevention programs (because it was the chaplains). Three officers from other units indicated they did suicide prevention because the chaplain in their AO was not doing suicide prevention or did it poorly.

RECOMMENDATIONS

1. Ensure UMTs are 100% filled in a combat environment, especially at brigade and battalion levels.
Supervisory UMTs are critical to ensuring that subordinate UMTs are appropriately staffed, are accomplishing the mission according to standard, and that commanders are aware of the value and need to own and resource religious support. UMTs at all levels must be fully staffed – particularly under combat conditions – as this is the chaplaincy's "first mission." TDA organizations and home stations should be augmented by reserve chaplains and/or local clergy where necessary.

2. Improve Suicide Awareness and Prevention Programs.

Increase Tempo and scope of ASIST training. Chaplains and Assistants in both Active and Reserve Components need to attend ASIST training at the Basic level and be able to develop and implement programs in their unit at the company level or below. Supervisory chaplains, Family Life Chaplains, and Hospital Chaplains (at a minimum) should attend the longer ASIST "training-for-trainers" course in order to be able to conduct training for a variety of both military and civilian personnel in units.

Supervisory Chaplain's must be involved. Supervisory chaplains must monitor the programs of their technical subordinates and ensure that training meets the standard. This will probably involve interface with commanders and other leaders in the subordinate unit to ensure priority of the training is established on training calendars and that resources are provided to conduct training, to include place and company level participation. Supervisory chaplains should also have direct relationships with their primary care and behavioral

health counterparts to ensure the programs have multiple echelons of support in both UMT and behavioral health chains of responsibility.

Integrate with Behavioral and Primary Care Providers. Programs conducted at the battalion/company level, though coordinated and executed by the trained unit UMT, should include participation by behavioral care and primary care providers. At a minimum, points of contact should be established, published, and given to Soldiers and family members at the time of training. Ideally, actual personnel from behavioral health (either providers or enlisted BH specialists) should be present at such training and participate at appropriate levels.

3. Execute an aggressive UMT pastoral care outreach program.

A high percentage of Soldiers reported interest in receiving mental health support and/or screened positive for a mental health problem. However, data suggest that significant barriers are preventing Soldiers from receiving help, such as transportation constraints, knowing where to get help, mental health services not being perceived as available, and stigma. The data also indicated that chaplains were accessed at relatively low rates. Establishing a predictable, regular, and visible presence at the company/battalion level is essential.

UMTs can reduce and/or eliminate many of these barriers by physically going to Soldiers who need and/or want help. The UMT doctrine of 'Ministry of Presence' works when UMTs go out and live and work among Soldiers at the lowest levels. UMTs report that their outreach efforts are hindered by the limited logistical support they receive from commanders and leaders. UMTs must work with commanders and leaders to solve the transportation and communication issues they face in order to get UMTs out where Soldiers live and work. The supervisory chaplain is a critical link in keeping UMTs aware of appropriate and effective doctrinal ways of doing business and in communicating to commanders and leaders the importance of properly resourcing UMTs for mission performance.

4. Educate primary players in the Role of UMT involvement in Combat and Operational Stress Control.

Commanders and Leaders must embrace and own the complete Religious Support Program. Religious Support is a Commander's program. Officer Basic and Advance Courses, as well as NCO Basic and Advance Courses, need to emphasize the role of the UMT in providing for Soldier spiritual health, which is a significant component of behavioral and mental health. Leaders need to understand that their ownership of and logistical support for the Suicide Awareness & Prevention Programs and other UMT initiatives is essential to the effectiveness of those programs. Supervisory chaplains are a critical link in getting this message to commanders both directly and indirectly through the higher chain of command.

Medical Personnel, both primary care and behavioral health providers, must understand the role of UMTs in support of total Soldier well being. AMEDDC&S needs to utilize their own Department of Pastoral Ministry Training to educate officers and NCOs about the role of UMTs and the mutual benefits both staff and patients of inter-disciplinary peer relationships. MEDCOM Medical Centers and Army Community Hospitals need to use chaplains in in-service training for medical personnel. FORSCOM Combat Support Hospitals need to ensure UMTs are a regular part of hospital patient care and treatment programs and include Pastoral Care as a training topic for personnel.

Chaplains need to understand their own role in COSC. FM 1-05 (*Religious Support*) has an Appendix B (FM 8-51, *COSC in Theater of Operations,* has the same appendix), which details COSC issues that UMTs should be aware of and ready to identify. That appendix needs more attention in training at both institution and garrison. The Chaplain Center and School should review how officer and NCO courses assist UMTs to work with COSC issues, make assessments and referrals to Behavioral Health personnel, and in general the role of the UMT in working with all medical personnel to provide easy access to care for Soldiers who have needs. Garrison and supervisory chaplains need to include a review of FM 1-05, Appendix B, with perhaps the assistance of local CSC providers, to sustain and improve skills.

MEDCOM UMTs and FORSCOM UMTS assigned to FORSCOM medical units should also attend the new COSC course that the MHAT is proposing for the AMEDDC&S (based on the current 2wk long OT COSC course). Other UMTS may consider attending the course as well and it should be included in the list of courses that DPMT offers to the Army chaplaincy.

5. Develop and field a spiritual health needs assessment and unit climate tool for the operational environment.

In order to accurately and systemically determine the spiritual needs of deployed Soldiers and ensure those needs are being met, a standardized “spiritual needs assessment” should be developed. Such an instrument must be easy to use, be compatible with the similarly developed behavioral health needs assessment, and contain some spiritual-unique elements. A Soldier/unit climate tool would also be helpful in order for UMTs to be able to keep a finger on the pulse of the unit climate in a more defined manner than traditionally done. Such tools supplement, but cannot replace, “ministry of presence” and the “personal delivery of religious support.”

APPENDIX 11 (References) to ANNEX B to OIF MHAT REPORT

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